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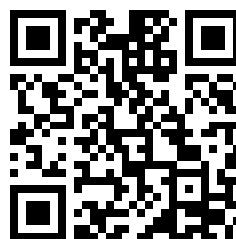
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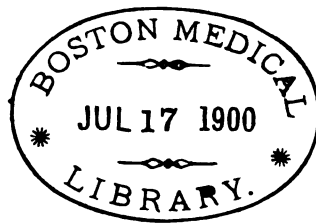
OF

MEDICINE AND MEDICAL AFFAIRS.

FROM JANUARY TO JUNE,

1900.

LONDON : 20 & 21 KING WILLIAM STREET, STRAND, DUBLIN : 19 LINCOLN PLACE.



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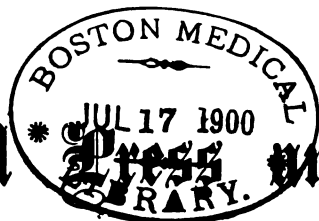
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Lecture on THE CINEMATOGRAPH AND THE TEACHING OF SURGERY. (a)

By PROF. E. DOYEN, M.D.,
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Translation by A. A. Warden, M.D. Glasg. (Clinical
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ANIMATED photographs were at first used as an entertainment. Only short scenes were represented, a row of films, 18 metres in length, system Lumière or Edison, at the rate of sixteen pictures a second, lasted exactly one minute. The vibration of the picture, always fatiguing to the eye of the spectator, became intolerable when it was a matter of reproducing complicated subjects. Only in the open-air or in a special studio could good negatives be obtained. I endeavoured several years ago to apply the cinematograph to surgical instruction, but was unable to overcome the difficulties referred to; the films were not sufficiently sensitive for the most powerful lenses then in use, and it was impossible to obtain satisfactory results with the apparatus of those days except in the case of a movement of very short duration. Operations on the dead body could easily have been photographed in the open air, but would have had no scientific interest or value. In all medical schools there is an amphitheatre for operative surgery where the use of instruments and technical details may be demonstrated by the professor at each lecture. The students practice on the dead body the ligature of arteries and the various sutures. It is even possible to imitate the flow of blood by connecting the aorta and the carotid with a raised recipient filled with coloured water. These practical experiments give but a very faint idea of true surgery. An operation on a dead body can never be compared to an amputation on the living subject. With a view, therefore, to supplementing this notoriously defective system of instruction, we must have recourse to the cinematograph and reproduce real operations. With the projections we shall be able to explain to our students the difference which exists between real and operative surgery, which has been rightly termed the "Surgery of the Dead."

If we go on to consider such operations as the removal of the kidney, of the thyroid gland, ovariectomy, hysterectomy, the difference becomes more marked, and operative surgery can only be considered the complement of topographical anatomy. The student will study, for instance, the different layers he must traverse to reach the kidney, its exact position, and the relations of its blood vessels. In thyroidectomy or hysterectomy he will appreciate the relations of the thyroid gland, the great vessels of the neck, and the

laryngeal nerves, the exact position of the ureter, the hypogastric, uterine, and vesical arteries. A certain amount of practice can even be obtained in the surgery of the stomach and of the intestines, and familiarity with the blood supply of these organs, the action of the various clamps, and the arrangement of the sutures. But operative surgery will never confer the gift of operating.

Do our books fill the gap thus left? Certainly not. The most detailed descriptions, the best diagrams or photographs of the various steps of an operation are inadequate. Take, for instance, the clamping of the broad ligaments in vaginal hysterectomy. Surgeons who have not seen my crushing forceps used cannot grasp its simplicity, and photographs of the various steps of the operation can only give them a partial idea. On the other hand, with the cinematograph we can make hundreds of people follow in one minute what a whole lecture could not make clear to a limited number of students. Thus there is accumulating in medicine a mass of more or less useless literature, descriptive and critical, and due appreciation of new methods becomes impossible. Surgeons themselves cannot derive the full benefit of visits to foreign schools, and only fifteen or twenty of those who assist at an important operation can follow with profit the details of the technique. The safety of the patient demands that spectators should be at a certain distance; the hands of the surgeon and his assistants conceal part of the field of operation, and the surgeon himself may be the only one to follow some of the more delicate steps. It is not sufficient to follow the operation, as it were, secondhand; but the author of the technique, the master himself, must be seen at work. The surgeon is judged by his work, and no text-books, however well illustrated, can sufficiently express his personality.

It has been with the object of completing our means of teaching the art of surgery that I have been led to study and employ the cinematograph.

The first operations taken by the cinematograph were a craniectomy and an abdominal hysterectomy. The films thus obtained by M. Clément Maurice with the Lumière apparatus, and by Monsieur Parnaland with his own invention, were sufficiently clear to show the value of the method. The first demonstration of the teaching of surgery by the cinematograph took place at the annual meeting of the British Medical Association in Edinburgh in July, 1898. Three films were shown:—

- (1) The manipulation of my operating table.
- (2) An abdominal hysterectomy.
- (3) A craniectomy.

This first demonstration was conclusive and so satisfied the physicians present that I was asked to give a second the next day.

And yet no one has shown a satisfactory series of films since July, 1898, the date of my first demonstration in Edinburgh, the priority of which has never been disputed. Since the meeting of the British Medical Association in Edinburgh I have added to

(a) Paper and demonstration given before the British Gynaecological Society, December 14th, 1899.

my collection of films, which will be issued in a few months for use in teaching faculties. With each film a full description, clinical and pathological, will be supplied. Surgeons who may wish to use the cinematograph themselves, either in operating or in teaching, are welcome to ask us for any details which may spare them errors and expense. Students abroad may thus follow the technique of the great surgeons of the world, they can compare methods and follow the progress of surgery. The historical value of such a possession can hardly be denied. What do we know of the prowess of Maisonneuve, of Lagenbeck, of Billroth or of Péan, who yet are, it may be said, of our own day? How valuable could we follow now with the cinematograph those marvellously rapid operations without chloroform, on the field of battle or in the operative theatre, and see once more the courage of the patient and the skill of the operator.

The progress of surgery is such that what is good to-day is improved upon to-morrow. Thanks, however, to the cinematograph, future surgeons will be better able to judge of the real progress accomplished.

Finally, and perhaps most unexpectedly, the surgeon himself may greatly benefit by the cinematograph. When I saw for the first time one of my operations reproduced on the screen, I recognised how far I fell short of my ideal. Many details of technique that had seemed satisfactory I now saw to be defective, and the cinematograph has thus enabled me considerably to correct and simplify, and to perfect my operative technique. My first films also show the personal progress that I have been able to make. Our films are so clear that the most delicate manoeuvres, such as the suture of the pelvic peritoneum in abdominal hysterectomy, and the opening of the dura mater in craniectomy, may be followed.

You will notice that each operation is done methodically. The patient, the movements of whose respiration can be followed on the screen, is anaesthetised; there is no suffering, and the loss of blood is trifling. The surgeon is calm; his movements are precise and calculated. When he makes a muscular effort you can see his biceps harden, his face contract, his whole body place itself in the most favourable position. The cinematograph registers the whole scene as it takes place, faithfully, rapidly, and in detail. Each step can thus be studied, analysed, criticised. The surgeon can assist at and calmly study his own operations. He can see in his face the anxiety of the moment. He can see himself superintending the respiration of the patient under the anaesthetic. He can see his whole mind set upon the successful execution of some movement, and almost anticipate the smile of relief that follows its accomplishment. Unnecessary gestures and movements may be noted and avoided. The cinematograph has more than once almost startled me in the resemblance I could not help seeing between myself and my late father, Dr. Octave Doyen.

The hours that I have spent with M. Clement Maurice and my assistants studying my technique with the help of the cinematograph have been of the greatest interest and value.

It is a help to all. The anaesthetist is surprised to see himself nervous and anxious at one moment, calm and attentive at another. The nurses who bring the thermo-cautery or who lift away the tumour removed, may see any clumsy movement and correct it.

There seems further no objection to the presence of non-medical spectators at these demonstrations. Members of ambulance societies are in the habit of going to hospital, attending operations, performing

dressings, and learning the principles of antiseptic surgery. Such persons may thus acquire knowledge which will be useful in the case of accidents before medical aid can be obtained.

The cinematograph could usefully be added to such a course of training, and first aid students might learn from it the duties they might later be called upon themselves to perform. And is it altogether to be regretted now, when all classes of society follow with such keen interest the progress of surgery, that the non-medical public should have other means of getting information than inaccurate descriptions? We hardly think so, and those who have seen operations as shown by the cinematograph admit that the calmness of the surgeon, the precision of his movements, the perfection of the operative technique, tend to diminish rather than increase the unknown horrors of an operation. The public will also learn this fact, that an operation as performed by one surgeon is a vastly different matter from the same operation by a different surgeon. There has been too great a tendency to believe that with the triumphs of anaesthesia and antiseptics, surgery has become all but inoffensive. It is time to protest against this error. The success of an operation depends much more upon the skill of the operator than upon the antiseptic care, which every surgeon ought of course to exercise. The cinematograph, registering the details of an operation with the proper speed and perfect accuracy, will show of what mettle the surgeon is made.

If you wish to publish a new procedure, add to your description several rolls of cinematographic films. Each original procedure can thus be compared with methods already published.

Those of my operations are short, and we have heard it said that the cinematograph "went more quickly than the operation." Turn the instrument yourself and you will see upon how little knowledge this criticism is based. If you turn too slowly the movement of the surgeon and his assistants are manifestly slowed; if you turn too quickly there is a rapidity and haste of movement that at once strikes the eye. The operation is only well reproduced if you turn at the same rate as at the moment of operating. My operations, therefore, last just as long upon the screen as during their actual performance. Most of them are not complete; the toilette of the field of operation, the completion of the sutures offer little interest, and would uselessly add to the difficulty and expense of the photographs. The projection that lasts five minutes appears extremely long. Thanks to the cinematograph, I have been able to defend myself against the reproach that I operated too quickly. Study several of the operations on the screen, and you will see that there is no haste and no useless movement, and that the operation is brief because the technique is simple and precise. Operate simply and you will operate successfully. "The more hurry the less speed," in French *hâtez-vous lentement*.

The progress of surgery during the last few years has been due far more to the improvement of technique than to the observance of the laws of antiseptics. The cinematograph will prove this better than descriptions or photographs. I have devoted myself for many years to the improvement of surgical instruments, to the simplification of hæmostasis and operative technique generally, and the cinematograph will make these methods known and permit colleagues abroad to judge of their value. I shall be sufficiently rewarded if I succeed in proving that operations should be simplified to the greatest possible extent, and every useless manoeuvre, every tedious and lengthy procedure, as far as possible

suppressed. In your hysterectomies, in your pylorectomies, in your craniectomies, adopt my technique, and you will be able to finish in a few minutes operations that by other methods will take you half-an-hour or hours. The loss of blood, which used to be considerable, will be trifling, the shock will be insignificant, the recovery rapid. What can the patient gain from a long operation? It would be judicious to operate slowly if slowness were one of the chief factors of success, whereas the contrary is the case. I have never sacrificed safety to speed. I operate at the same time more simply and more surely, whereas the prolongation of an operation adds to the gravity of the prognosis. Do in an hour a hysterectomy that I would do in ten minutes, and in those fifty minutes you will tax the patient's strength by useless movements that may irreparably compromise the vitality of the tissues. The prolongation of the anaesthesia, the increase of the loss of blood, will further injure your patients, and it is thus that operations of two or three hours duration have such a heavy mortality. "Time is Life."

Lectures with the cinematograph should be given as follows:—

(1) The professor briefly describes the operation, and shows upon the screen projections of the principal instruments to be used.

(2) Each step of the operation is shown in detail by fixed projections either of photographs or drawings.

(3) When the technique is thoroughly understood the operation itself is shown on the cinematograph.

If the professor has films of several cases of the same operation, he demonstrates the technique and the necessary modifications in the different cases.

The students need no longer crowd the operative theatres as more or less unintelligent on-lookers. They will be obliged to follow a preparatory course before they actually assist the surgeon. They will then be able to draw profit from his lectures and from the operations themselves.

The application of the cinematograph may be considered one of the greatest improvements in the teaching of operative surgery, since it will make known throughout the world the best methods and the surest means of saving part of humanity from suffering and from death.

THE HYSSOP:

ITS BOTANICAL HISTORY; ITS SYMPTOMATOLOGY; ITS TOXICOLOGY AND ITS THERAPEUTICS.

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ABOUT a year ago my attention was specially called to the subject of this paper by reading a short editorial on "A Case of Poisoning by Hyssop" in the pages of the MEDICAL PRESS AND CIRCULAR, which appeared January 15th, 1899. Before that date I knew of the therapeutic application of hyssop only from reading; and I believe, I had never heard or read of a case of poisoning due to its administration. Curiosity then induced me to "make up" the subject, and I collected notes from various sources with a view to possible publication. Other more pressing engagements, however, called away my attention from a topic apparently of minimum interest to the majority; with the natural result that my notes got mislaid. I turned them over a few days ago, in rearranging some papers; and, on glancing over their contents, they appeared to me, even after so long an

interval for the cultivation of second thoughts, to contain a sufficient proportion of mental nutriment to justify my bringing them under the notice of the readers of this journal.

The botanic and therapeutic literature of the modest plant which is (popularly) believed to have marked the zero level of the cerebral barometer of the wisest of men is, as we shall see, an extensive one. The foremost place in this selection I give to one of the most exhaustive and copious of British herbalists, John Parkinson. The first chapter of the vast *Theatrum Botanicum* of this writer is devoted to the study of the Hyssop—in all its varieties and their virtues. Those of my readers who have not an opportunity of consulting this great storehouse of antiquated botanical therapeutics may be glad to have an opportunity of perusing his descriptions.

"Hyssopus. Hysope."

"There are sundry kinds of Hysops, whereof the most are unknown to many: whose descriptions, names, and properties shall follow.

"1. *Hyssopus Vulgaris*, common garden Hysope. The common garden Hysope is so well known to all that have a garden, or that have been in a garden, that I shall but seeme *actum agere* to bestow my time in describing it to be a small bushy plant, that riseth up more than a foot high; with many woody branches, but tender; at the tops whereof are set at certaine distances, sundry small long and narrow greene leaves: at the tops of the stalkes stand blewish purple gaping flowers, in spiked heads one rowe above another: after which follow the seed, which is small and blackish; the roote is somewhat woody with many threddy strings; the whole plant is of a strong sweete sent.

"2 and 3. *Hyssopus foliis nireis*: & *foliis aureis*. White Hysope, and golden or yellow Hysope.

"These two sorts of Hysope are both of the same kinde with the common Hysope, but differre only in the party colouring of the leaves; the white having diverse leaves parted white and greene in the midst, and some all or most part white, and some wholly greene, or with some stripes in the greene; for all these sorts are seene together upon one Plant. The golden or willow sort, hath the uppermost leaves usually wholly yellow in the summer time, parted with greene; the lower leaves often abiding without discolouring.

"4. *Hyssopus foliis cinereis*. Russet Hysope.

"This russet hysope also differeth from the former in no other chiefe matter, than in the colour of the leaves, which are of a grayish or ash colour, which some call Russet; this is likely to be that sort that Bauhinus saith was sent him from England.

"5. *Hyssopus surculis densis*. Double Hysope.

"This Hysope groweth lower, and thicker set with slender and not so woody branches, bending somewhat downwards, and much more thicke set with leaves of a darke greene colour; in the flower and other things it differeth not from the first.

"6. *Hyssopus latifolia*. Broad-leaved Hysope.

"This also differeth not from the first here specified, but in having larger and broader greene leaves, upon more woody stalkes, keeping forme and substance.

"7. *Hyssopus foliis crenatis*. Jagged or dented Hysope.

"This difference of the dented leaves, maketh me to set it downe as another species hereof, as others have done.

"8. *Hyssopus moschata vel de cilissa*. Musk Hysope.

"Gesner in *Hortis Germaniæ* remembreth this Hysope to differre nothing from the ordinary Hysope, but in the sent, which is so gracious and pleasant, that it cometh nearest to the sent of Muske.

"9. *Hyssopus Arabum floribus rubris vel albis*. White or red flowered Hysope.

"The red or white flowered Hysope differ but a little from the garden sort, yet are distinguished from it in that they both doe usually beare red or white flowers, all on one side of the spike, yet continue not constant in that forme, but change into the forme of the ordinary kinde.

"10. *Hyssopus minor sive Hispanica*. Dwarf Spanish Hysope.

"This Spanish kinde is a smaller and lower sort, whose branches rise not so high as the garden Hysope, but bend a little downwards, the leaves also being smaller and thicker, and of a sadder greene colour, and the heads or spikes are also shorter, but the flowers are purple like the garden sort. Lobel calleth this *Hyssopus parva augustis foliis*

"11. *Hyssopus Coronatasive Comosa Clusii*. Tufted Hysope. Tufted Hysope is in leaves, flowers, and manner of growing somewhat like the common or garden kinde, but a little smaller and lower, the leaves being of a paler greene colour, and the top branches spreading a little broader, having shorter spikes of leaves and flowers growing as it were in tufts, which hath caused the name, and noted it for a difference.

"12. *Hyssopus foliis crispis*. Curld Hysope. Curld Hysope hath the leaves curled or crumpled at the edges, that each leaf seemeth to be composed of many; and herein consisteth the chiefest difference.

"13. *Hyssopus montana*. Mountaine wilde Hysope.

"Mountaine or wilde Hysope is very like unto the garden kinde for the manner of growing; but that the leaves which are not so many at a joynt, are somewhat harder and rougher, and a little hairie, and somewhat narrower also, which (as Matthiolus saith) being brought into gardens, and there cherished; will by time put off that roughnesse, and become more mild and gentle, the taste whereof is much more bitter, and nothing so hot or sweete as the common kinde: the flowers and seedes are like the garden sort, both for forme and colour.

"14. *Hyssopus angusti folia spicata*. Narrow leafed Hysope.

"Narrow leafed Hysope is a fine kinde, and hath many slender hard stalkes, whereon are set at distances, as in the common Hysope, many small greene leaves, but larger and narrower than they, and ending in a longer point: the flowers likewise grow at several distances, as it were in roundles, almost from the middle of the stalke up to the topes, of a blewish purple colour like the ordinary kinde, but much smaller and so is the seede also: the branches hereof will take roote and grow being laid into the ground, the roote spreading much in the earth.

"15. *Hyssopus foliis origani*. Pound leafed Hysope.

"This Hysope hath divers hard woody stalkes, whereon grow sundry small and almost round leaves, one against another, but pointed at the endes, the heads or spikes of flowers are like unto the common sort, of a blewish purple colour; the sent also differeth little from it.

"Gerard hath set forth an hysope with the leaves of Nummularia. Monyworte, which peradventure might bee this kinde, yet I never saw such an one with him.

"The Place—Pena saith that one common Hysope groweth on the hills of Romania about Verona, and neere unto Mount Raldus; the dwarfe kinde in Spaine, and the mountaine wilde kind, on the hills in many places of Germany, and as Matthiolus saith, on the hill Salvatin in the country of Goritia; the rest, with these also when they may be gotten, are noursed up in the gardens of the curious.

"The Time.—They doe all flower in the summer months of Iune and July, and their seede is ripe in the beginning or middle of August.

"The Names.—It is called in Greeke, *ὑσσωπος*, sic dici putant quasi *ὕμενον* (pro *χρυσομένον*) *ἐπιτον ὠρα* quia super vultus affunditur; in Latine *Hyssopus* & *Hyssopum*; of the Arabians, *Cyfe*, *Iufa*, and *Iaves*; of the Italians and Spaniards, *Hissopo*; of the French, *Hissope*; of the Germans, *Isop*; of the Dutch, *Japen*; and of us, *Hysope*. The names of every one of them are sufficiently expressed in the titles and descriptions of them. But there is a great controversie among our later writers, what hearbe should be the true Hysope of Dioscorides, and other the Greeke authors: for that our common Hysope is not it, but is the true Hysope of the Arabians, as all doe acknowledge except Matthiolus, who doth earnestly contend that our garden Hysope is the same of Dioscorides, whose arguments are too weake to perswade any to be of his opinion, for the description of Dioscorides his hysope hath no face or true resemblance with ours, his bearing tufted heads like *Chrysocome* or *Goldilocks*, as he compareth it, and ours in spikes: the leaves also of his are like unto the *Origanum Onitis*, which are somewhat round like *Marjerome*, as you may see heere shortly after, and are not narrow and long, as those of our Hysope are: therefore *Lugdunensis* setteth forth a round leafed Hysope, which he taketh to be the true Hysope of Dioscorides, but neither are the leaves thereof whitish, as those of *Onitis*, nor doe the heads much differ from the common Hysope: Lobel also propoundeth another, that is our pot *Marjerome* to be the right, in that it hath roundish leaves like *Origanum*, and tufted heads of flowers that are spread abroad like it also, this he saith, is the likeliest hearbe, comming nearest unto the true kinde, unlesse as he saith, it may be referred unto an *Origanum*: but *Fabius Columna* confuteth that of Lobel and *Pena*, as well for that the tufted heads, are more like unto wilde *Marjerome*, then unto *Chrysocome*, or garden *Marjerome*, as *Cratervas*, *Serapio*, *Isaack*, *Mesues* and others doe compare them, as also that the leaves of Dioscorides his hysope, are whitish like unto *Origanum Onitis*, which those of Lobels *Marjerome* is not; besides this, that it is a kitchen hearbe, fit for meate and sawce, and so is our ordinary Hysope also, and not a physicke hearbe as Dioscorides maketh his to be: and lastly, that neither Lobel his *Marjerome*, nor yet our Hysope, are equall in the properties unto that of Dioscorides and others, howsoever it is usually received in the steede thereof: thus saith *Fabius Columna*, and therefore by many reasons would perswade us to beleve, that our ordinary *Polium montanum* is the true hysope, as well for that the leaves are white, and the heades of flowers like unto *Origanum* and *Chrysocome*, as he saith, as also for that his vertues and properties by the bitterness thereof, are more effectuell in all the diseases, whereunto *Plinye* applies his Hysope, which are not remembered of Dioscorides; and that although Dioscorides maketh no bitterness in his Hysope, yet *Serapio* doth as he saith: thus much *Columna*. But let me say, seeing he himself saith, that our *Polium* is answerable in all the parts thereof, unto the *Polium* of the ancients I see no good reason why it should be their Hysope also, and therefore I think, we may as well refuse his *Polium*, as he doth Lobels *Marjerome*. Others, also, would make *Gratiola* to be the true Hysope which hath lesse likelihood than any of the former. *Bauhinus* in his *Pinax* would make our ordinary *Rosmary* to be the Hysope of the Hebrewes, taking peradventure his ground from the Scripture, in *Saint Johns Gospell*, the 19. chap. and 29. verse, where the souldiers bound a sponge wet in vinegar to the end of an Hysope stalk, to put it to our Saviour's mouth when he was on the Crosse, in that the ordinary hysope hath not so long a stalke, as might reach up so high: but both the Evangelists, *Matthew* and *Marke* say it

was a reede, and it may be that the Hysope stalke was bound therevnto, for Saint Iohn as an eye witness of what was done, calleth it as before : Now it is not likely that the Iewes had an other Hysope, divers both from the Greekes & Arabians; but rather that their Hysop was the same of the Arabians, being their neere neighbours, and as it should seeme, was so familiar to their country, that it grew on mudde-walles, as the Scripture saith that Solomon spake of it; which I verily thinke Rosemary doth not. But Hysope is often mentioned in the Scripture to be used in the Iewes ceremonies, which was not without material signification; for as Saint Paul saith, all was done among them in types and figures, and to bee rightly understood and well applied, were worthe of much observation and good use. Now although the true Hysope of Dioscorides, and the other Greekes, is not yet certainly knowne, yet assuredly this which is knowne, and generally received, may safely be used in the stead thereof, untill the true Hysope may be knowne.

"The Vertues.—Dioscorides saith, that Hysope boyled with rue and hony, and drunke doth helpe that that are troubled with Coughes, shortnesse of breath, wheesing, and rheumaticke distillations upon the lungs; taken also with Oxytel, it purgeth grosse humours by the stooles, and with hony killeth the wormes in the belly, and taken also with fresh or new figges bruised, helpeth to loosen the belly, but more forcibly, if the roote of the Flower deluce and Cresses (yet some copies instead of Cardamon have Cardamomum, which I never knew put into any purging medicine in our times, and Macer his verse doth intimate cresses thus: *Cardama si jungas his solves fortius alvum*), be added thereunto: it amendeth and cherisheth the native colour of the body, spoyled by the yellow-jaundice, helpeth the dropsie and the spleene, if it be taken with figges and nitre: being boiled with wine, it is good to wash inflammations, it taketh away the blew and blacke spots, and markes that come by strokes, bruises, or falls; being applied with warme water; it is also an excellent medicine for those, that are troubled with the Quinsie, or swelling in the throate, to wash and gargle it, being boyled with Figges; it helpeth the tooth-ach, being boyled in vinegar and gargled therewith; the hot vapours of the decoction, taken by a funnell in at the eares, easeth the inflammations of them, Mesues saith the singing noyse of them; Pliny addeth, that it is an enemy to the stomacke, and provoketh casting being taken with figges; being bruised, and salt, hony, and cumminseeds put to it, it helpeth those that are stung by serpents. Galen is very briefe herein and onely saith, it is hot and dry in the third degree and of thin parts. Matthiolus saith, that our Hysope is of thinn parts, and that it catteth & breaketh tough flegme, it rarifieth or maketh thinn that which is thick or grosse, it openeth that which is stopped, and clenseth that which is corrupt: the oyle thereof being annoynted killeth lice, and taketh away the itching of the head, it helpeth those that have the falling sicknesse, which way soever it be applyed, but more especially being made into pills in this manner. Take of Hysope, Horehound, and Castoreum, of each halfe a dragme, of the roote of Peonye (the male kinde is most proper in this disease) two drammes, of Assafetida one cruple, let them all bee beaten as they should be, made into seven pilles (or more if they be too great) with the juyce of Hysope, and one of the greater, or two small ones, taken every night going to bed is appointed, the best Physitians of our tymes, assuredly doe account it, to be hot and dry in the third degree, and of thinn parts; for being sharpe and a little bitter withall, they apply it effectually, for all cold griefes or diseases of the chest and lungs, helping to expectorate tough

flegme, that stuffeth or oppresseth them, being taken either in a *lohoc* or licking medicine, or in a Syrupe, or any other way, and in a decoction thus; take an handfull of Hysope, two ounces of Figges, and one ounce of Sugar candy, boyle them in a quart of Muscadine, untill halfe a pint be consumed, which being strained, taken morning and evening, availeth much for those that are troubled with an old cough, by causing the tough flegme the more easily to be avoided: it helpeth also to provoke urine being stopped, or that is made by dropes: it helpeth to breake winde, and to cause women's monthly courses, and easeth the sharpe fitts of agues; the greene hearbe being bruised, and a little sugar put thereto, doth quickly heale any greene wound or cut in the hand, or elsewhere being applied thereto."

(To be continued).

Clinical Lecture.

OTORRHEA AND ITS TREATMENT. (a)

By DR. PAUL RAUGE.

It is unnecessary for me to insist upon the great practical importance of the subject of otorrhœa and its treatment, as there is perhaps no symptom with which medical men have more frequently to deal, and no other affection is more apt to defy his skill and prejudice his professional reputation.

The two most salient features of discharges from the ear are their frequency and their tenacity. This double characteristic is however readily explained by a close examination of the conditions governing the development of otorrhœa and its persistence, that is to say, the bacteriological reasons for suppurative of the tympanum, and the anatomical reasons of its persistency for an indefinite period. No rational treatment of a continuous discharge from the middle ear or its accessory cavities is possible without a thorough appreciation of these two points in the ætiology of the affection. Why is this region more than any other exposed to suppuration, and why does this suppuration persist indefinitely when present? The answer to these questions logically involves the rules of both prophylaxis and treatment, for there is no way of preventing otorrhœa unless one knows how it originates, and no possible means of stopping it, if the reason of its duration is not clearly understood.

The middle ear appears at first sight to be admirably protected against pyogenic microbes, were it not that the tympanum is in communication with the outer air by the Eustachian tube. The existence of this canal deprives the tympanum of all the benefits which it otherwise would derive from its isolation.

The danger is the greater, because the canal opens into a particularly unhealthy region, the naso-pharynx, in which all kinds of micro-organisms abound, even under normal conditions. As long as the lumen of the tube remains as narrow as it is normally, so as to prevent the liquids of the pharynx from passing through with the air, when it is opened at each deglutition, in other words, as long as the functions of the apparatus are regular, the middle ear is protected, and the presence of the tube is no more a source of danger than is the well corked opening of a glass bulb for the purity of a culture.

But if, for some reason or other, the impermeability of the tube is defective, so that some of the microbes in the pharynx get a chance to pass through, mischief results. When pus from an otitis media is collected aseptically and examined immediately after incision of the tympanic membrane, it is as a rule found to contain only a single species of microbe (Zaufal, Netter, Moos), which occupies the field alone as long as the cavity is closed. The moment an artificial or spontaneous opening

(a) Translated for the MEDICAL PRESS AND CIRCULAR from *La Semaine Médicale*.

in the membrane occurs or is created secondary infection becomes possible.

As long as the pus formed in the middle ear remains shut up in the cavity, protected from outside contamination by the still intact tympanic membrane, cultures of this pus present the character of purity and homogeneity, to which attention has been called above. But when communication has been established between the primary focus and the exterior, either through spontaneous perforation or a surgical incision, secondary infections follow in rapid succession, saprophytic species mingling with the pathogenic micro-organisms, and the original invaders in many cases disappearing before the advance of fresh hosts. The microbe of old-standing otorrhœa is the staphylococcus pyogenes, which is as frequently met with at this advanced stage, as it is rare at the onset of the affection. The white variety is the most common, but whether white, yellow, or straw-coloured, whether penetrating through the Eustachian tube or the auditory meatus, whether propagated by the air, cultivated in the cerumen, introduced by the fingers of the patient, or originating in a septic dressing, the staphylococcus unquestionably, in old-standing otorrhœa, occupies the same place as the pneumococcus or the streptococcus at the onset of the affection. It appears, therefore, that, though clinical forms of otitis cannot, as Zaufal suggested, be distinguished by the presence of this or that microbe, their successive appearance, at any rate, marks the different stages of the disease.

Now as to the peculiar conditions which cause suppuration, when once established in the middle ear, to persist with a tenacity, unknown in respect of any other natural cavity, the explanation thereof is to be found in the anatomical features of the middle ear and its accessory cavities which are the sole cause of the persistence of otorrhœa.

Three conditions especially contribute to make this region a sheltered nook, in which pyogenic microbes are enabled to increase and carry on their mischief undisturbed, viz., the irregular form of the cavity, the extent of its walls, and the difficulty of gaining access to it. At the extreme end of the narrow passage, formed by the auditory meatus, is the tympanic membrane, and on the other side of this is a larger cavity, the tympanum properly so called. Although the difference in size between this region and the passage leading to it extends to all parts, it is much more marked above than below, the floor being barely a millimetre lower, so that, on entering the tympanum from the auditory meatus, the floor is almost on a level with the latter, whereas the roof suddenly rises at the point of junction between the two cavities, as soon as the tympanic membrane has been passed. The middle ear, therefore, in respect of the auditory meatus, occupies the same position as the dome or steeple in respect of the nave of the church, whence the name of cupola or attic has been given that part of the tympanum which is situated above both the auditory meatus and the tympanic membrane. It is obvious that this high region must necessarily be inaccessible to ordinary methods of exploration, and that it is as impossible to see the roof of the tympanic cavity through the auditory meatus, as it is from the porch of a church to see the dome towering above it at the other end.

The attic representing, as I have stated, the region of the tympanum which reaches above the tympanic membrane, it follows that its external wall is not formed by this membrane, but by a plate of bone, separating it from the auditory canal, the plane of which, slanting downwards and inwards, forms with the membrane an obtuse angle with the apex turned inwards and upwards. This osseous wall is the obstacle which prevents the attic from being seen, and it is this wall that must be demolished, in order to reach the chamber of the auditory ossicles, whether this be done through the auditory canal, or a wider path be opened by incision of the soft parts behind the pinna (Stacke).

The portion of the tympanum, which is not only hidden from view, but inaccessible to therapeutical measures, is of capital importance in the history of otorrhœa. As a matter of fact, this is the place

where the mischief lurks in the majority of cases of inflammation of the tympanum, and in all observations of otorrhœa "caries of the ossicles, suppuration of the attic" are standing headings. The almost invariable association of these two conditions shows that one is the consequence of the other, and that the frequent occurrence of suppuration of the attic, far from being accidental, is the result of the fact that it lodges the two larger ossicles, which are so often affected by caries in suppurating otitis. It is, in fact, in this upper part of the cavity of the tympanum that the joint is situated which unites the head of the malleus to the body of the incus. Being thus concealed in the dome, there is nothing seen of the ossicles below, except their descending processes (the handle of the malleus and the long process of the incus), hanging down like the bell ropes in a steeple.

Although, from a physiological point of view, the tympanum is the really active part and the centre of the middle ear, it does not by any means represent the entire cavity, which is the seat of the pathological phenomena under discussion. As a matter of fact, it constitutes only a comparatively small part of the irregular space hollowed out in the temporal bone, which in addition comprises the antrum and the mastoid cells. From a pathological point of view, this cavity must be considered as a whole, without taking into account the subdivisions which anatomists have seen fit to make, for the various parts of which it is composed communicate freely with each other, and inflammatory lesions are therefore not limited to any particular portion. It may even be truthfully asserted that the tympanum, properly so-called, is of less importance pathologically than its accessory cavities, on account of the large extent of surface presented by the labyrinth of mastoid cells.

At the postero-superior angle of the tympanic cavity is situated the large orifice by which this cavity is continued into the alveoli of the mastoid process. This orifice leads to a slightly ascending canal (the petromastoid or tympano-mastoid canal, or aditus ad antrum), which opens, behind and above, into a large egg-shaped cavity, the axis of which is antero-posterior and forms the continuation of that of the canal. This is the mastoid antrum. Hollowed out in the base of the mastoid process, and separated from the outer surface by the shell, the cells of which surround it on all sides, the antrum is in reality only the largest of these cells, forming a sort of central hall, around which the secondary cavities are arranged, and into which they all open. On section, therefore, this part of the temporal resembles a wasp's nest, though the alveoli do not open toward the outside, but into a central cavity, around which they form a radiating layer, thicker toward the outside, and especially below. This summary description is sufficient to show that, in the mastoid cavities, the conditions are eminently favourable to copious and lasting suppuration; copious because the secreting surface is enormously increased by the innumerable lamellæ forming the partitions in the alveolar tissue; lasting because each and every cell affords a hiding-place for infective agents. The only effective treatment consists in laying siege, as it were, to each separate alveolus.

Modern anatomo-pathological researches, and the more and more numerous operations performed of late on the mastoid process, have completely changed the views formerly prevailing as to the frequency of this association. Instead of regarding secondary mastoiditis as exceptional and merely as a complication of otitis, it is generally admitted nowadays that it is the almost inevitable consequence of every inflammation of the tympanum (Politzer, Tillaux, Duplay, Luc, Lubet-Barbon, and Broca). It is exceptional, however, for otitis media to stop at the aditus, without overstepping the artificial boundary-line drawn for the purpose of anatomical description between two cavities which are continuous, lined with the same mucous membrane, and obviously exposed to the same pathological influences. There is no doubt that the inflammatory process almost invariably begins in the tympanum, and that it may remain limited to this part of the

cavity as long as it is acute and recent; but when it becomes chronic, one may be assured that the entire cavity is affected, and that the inflammation has been propagated, in a more or less latent manner, to the base of the mastoid cells. All operators have therefore arrived at the practical conclusion that a surgical intervention, to be efficacious, must not be limited to opening the tympanum, as Stacke thought might be done, but that it is necessary to continue the path through the bone, along the aditus, as far as the mastoid antrum and cells.

Although there are as many varieties of treatment as there are forms of otorrhoea, the whole matter may be summed up, I think, for practical purposes under four heads, viz.:—

1. There is as yet no otitis, but an affection in the neighbourhood, such as purulent coryza, pharyngitis, adenoid tumours, and hypertrophy of the tonsils, or a constitutional disease, such as measles, scarlatina, typhoid fever, or tuberculosis, renders this complication imminent. Precaution and prevention are then called for, in other words, the treatment should be prophylactic.

2. There is pus in the tympanum, but the membrane is intact, and thus insures isolation of the abscess.

3. The tympanic membrane is perforated, and the door opened for secondary infection; the acute otitis is becoming chronic, and has changed into otorrhoea.

4. The irritating action of the pus has gone beyond the mucosa, the bones being affected, the incus and malleus necrosed, the carious walls contain sequestra, and the lesions, passing along the aditus, have reached the antrum and mastoid cells.

Such are the various conditions which may call for intervention in the course of suppuration of the ear. I shall now discuss them in detail, in connection with the treatment adapted to each.

Prophylaxis against Abscess of the Tympanum—According to Moos, there are four ways in which pyogenic microbes may enter the ear, viz., through the vessels, the petro-squamous fissure, the Eustachian tube, and the auditory meatus. The latter, which, as I have shown, does not become permeable until at a late period when a perforation of the membrane permits the morbid germs to pass, plays no rôle at the initial stage of otitis, as long as the tympanic membrane is intact. With regard to the vascular and osseous entrance gates, they are so theoretical and apparently so rarely brought into play, while at the same time they are so inaccessible to any prophylactic measures, that it is safe to leave them out of the question in a practical discussion.

Thus only remains the Eustachian tube, to the capital importance of which in primary infection of the tympanum I have already called attention. It constitutes for the microbes of the pharynx the high road to the ear, the only one, in fact, which is always free and open. The orifice of the tube being the regular and normal path, so to speak, along which almost all suppurations without exception proceed, it is at the entrance to this canal that watch should be kept, in order to bar the access to it the moment danger threatens. Above all, the medical man should not forget that he is frequently himself the involuntary cause of a microbial invasion of the ear. An inopportune nasal operation, an imprudent catheterisation, or even a simple palpation of the pharynx or the use of the air douche, when the tube happens to be very wide or its orifice somewhat relaxed, may be sufficient to open the gate to the enemy. It is of the greatest importance therefore to exercise every possible care in any operation directly or indirectly involving the region about the opening of the Eustachian tube, and never to touch this dangerous spot without resorting to the most rigorous aseptic precautions.

The cavity of the naso-pharynx being the storehouse from which the infective elements passing through the tube into the tympanum are derived, it is self-evident that the condition of the pharynx must be carefully looked after, in order to protect the ear. Under normal conditions, it is true, the micro-organisms of this region are inoffensive, owing to the bactericidal properties of the mucus secreted as a measure of defence (Wurtz and

Lermoyez); but under the influence of a constitutional disease, such as influenza and eruptive fevers, or a localised lesion, such as tonsillitis, adenitis, and scrofulous rhinitis, the fluids existing in this region assume an infective character with which the natural defences are unable to cope. The organism then requires assistance in order to be able to keep off the enemy, and preservative measures must be resorted to at once. They consist in carrying away by irrigation the secretions of the pharynx and nose, neutralising the danger by antiseptic measures, such as nasal ointments and powders, and the application of antiseptic fluids to the pharynx, or better still, removing the cause entirely by a suitable treatment of the local affections, ablation of any adenoids which may exist, extirpating in whole or in part the hypertrophied tonsils, re-establishing the permeability of the nose by resection or cauterisation of the turbinates. In short, the treatment called for during this period consists in unremitting care in respect of the cleanliness of the pharynx so as to protect the orifices of the Eustachian tubes. Many cases of otitis, perforation of the tympanic membrane, and subsequent deafness would never have occurred, had the medical man protected the ears of his patients before they were affected, and remembered that prevention is the best treatment of otitis.

In my next lecture I shall deal with the treatment of special phases of these affections.

Clinical Records.

WESTMINSTER HOSPITAL.

Anuria—Transfusion of Saline Fluid—Nephrectomy—Death.

Under the care of Dr. MURRELL.

J. G., a married woman, æt. 47, was admitted on November 22nd, 1899, in a semicomatose condition. No history could be obtained from her friends except that she had passed no urine for two days. She was drowsy and stupid, but could be roused to answer questions, although her answers were monosyllabic and not to the point. She presented an alcoholic appearance. The temperature was subnormal, the pulse 60, there was no paralysis of the face or of the extremities. There was some hypertrophy of the left ventricle and a few scattered râles were heard over the bases of both lungs. The pulse was hard, the tension increased, and the vessels thickened. She made one or two ineffectual attempts at vomiting, but there was nothing peculiar in the odour of the breath. There were no convulsions. The pupils were equal, normal in size, and reacted to light. No ophthalmoscopic examination could be made. The trunk and limbs were covered with old indurated eczema, there was no œdema of the legs, but there was a little œdema about the loins. No urine was passed and there was none in the bladder. Much doubt was entertained as to the diagnosis, but it was thought to be a case of toxic uræmia. Two pints of saline fluid were infused by Mr. E. J. Stilwell into the vein of the right arm, and although the pulse improved in quality her general condition remained unchanged and no urine was secreted.

On the following day some tenderness was detected in the right kidney region and the patient was able to indicate this as the seat of pain. It was thought that possibly it might be a case of anuria due to blocking of one or probably both ureters by fragments of renal calculus. Mr. Walter Spencer, who saw her in consultation, advised right nephrectomy with the view of relieving obstructive suppression. Anæsthetic having been administered by Mr. Frank Bond under circumstances of considerable difficulty an incision was made over the region of the right kidney. There was more than an inch of œdematous fat from which a large quantity of serous fluid exuded. The kidney was found to be soft and vascular, and after incising the capsule Mr. Spencer made an aperture in the pelvis, with dressing forceps and finger. There was a free escape of serous fluid mixed with venous blood. The condition of the patient being unsatisfactory no further exploration was attempted.

and the wound was dressed with iodoform, and stuffed with antiseptic gauze. The patient on the following day was brighter; there was less œdema of the loins, and the abdomen, which had previously been tense, was softer. On passing a catheter into the bladder about a drachm of urine was drawn off, mixed with blood. The patient was unable to retain food or stimulants, and died six hours after operation.

At the post-mortem examination it was found that there was much hypertrophy of the left ventricle, and that the right ventricle was dilated and somewhat hypertrophied. The valves were normal, and there was much atheroma of the aorta over the whole length to the bifurcation. The liver weighed 51 ozs., and was nutmeg in character. The kidneys weighed 3½ ozs. each, and were markedly granular in appearance. Microscopically they were typically fibrotic and highly congested.

Transactions of Societies.

BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD DECEMBER 14TH, 1899.

The President, Dr. MACNAUGHTON-JONES, in the Chair.

Dr. E. DOYEN, of Paris, gave a

CINEMATOGRAPHIC DEMONSTRATION OF GYNÆCOLOGICAL OPERATIONS.

Before proceeding to the demonstration itself, he said:—Gentlemen,—Before giving you my ideas on the use of the cinematograph in the teaching of surgery, allow me to express my thanks to the eminent president of the Gynæcological Society, and to all the members, for the great honour they have conferred in electing me an honorary member. I shall never forget that it was in England at last year's meeting of the British Medical Association, that the cinematograph as applied to surgery was first shown. I had a certain dread in showing my English colleagues my first films. I felt that the idea of the application of the cinematograph to the teaching of surgery might appear strange to them, and I feared that they would view it rather as an exhibition without practical interest, or a vain attempt to make use of the ordinary cinematograph otherwise than a recreation.

The hearty welcome that my colleagues gave to the demonstration in Edinburgh, the public congratulation and encouragements given me by Professor McEwen, Prof. Simpson, and Prof. Chiene satisfied me that the members of the British Medical Association approved of the innovation. There is, however, yet more to acknowledge. After the cordial welcome of my colleagues at Edinburgh, after the great honour of being elected LL.D. of the University, it is once more on English soil that I am officially asked for the first time to give a demonstration of my operative technique as shown by the cinematograph. This century, so rich in great discoveries, will be memorable to the physician of the future as the century of bacteriology and of serum-therapeutics. The surgeon will know it as the century of anæsthesia and of antiseptics, that doubly solid basis of present-day surgery. And in the front rank of the pleiad of men who represent the surgery of the nineteenth century will stand for ever the name of the benefactor of humanity, the father of that antiseptic method without which which anæsthesia had been vain. Need I mention by name Lord Lister?

Initiated in the Listerian method in 1882 in Paris by Lucas-Championnière, practising surgery independently in 1885, my first object was to simplify operative technique and to shorten the duration of major operations which, even at that date, gave a heavy mortality. I set myself to apply to abdominal surgery the established principles of the operative surgery of the extremities as practised by the pre-antiseptic surgeons. My efforts were crowned with success. I have largely transformed surgical instrumentation, suppressed the lengthy and objectless steps of each operation, and by simplifying

the technique have shortened their duration. I have thus had the satisfaction of reducing to an almost unhopèd-for extent the death-rate of certain operations. The mortality of abdominal hysterectomy, in which my technique has been widely adopted, has fallen from 30 per cent. to 5 per cent., and the operation is completed in a third to a quarter the time.

Cranioectomy, by the flap operation, is performed in a few minutes. The duration of vaginal hysterectomy, of nephrectomy, of thyroidectomy seldom exceeds five to ten minutes, and, lastly, the use of my clamp forceps has considerably simplified the arrest of hæmorrhage from thick or vascular pedicles, and the technique of operations upon the stomach, the intestine, and more recently the gall-bladder.

This technique, gentlemen, which is the result of years of care and study is often so delicate in its details that the best description fails to make it clear. The most careful drawings or photographs from nature give but a feeble idea of the reality they are meant to convey. The cinematograph alone enables us to reproduce new methods and to show them abroad. Surgery is based first of all on the principles of anæsthesia and of antiseptics, which may be learned by all who bring the necessary patience and zeal to the task. The work of the surgeon is most difficult. Each day brings new operative procedures, more and more delicate, and more and more the idea spreads that in the future the most skilful surgeons, the best hand-workers, as the word means, will alone be worthy of the name. The teaching of operative surgery for such operations as cannot be demonstrated on the dead body has always been much inferior to the teaching of clinical surgery and of surgical pathology. Too few students could follow with profit the details of such operations in the operating theatre. The cinematograph will fill this blank and complete the surgical training we give to the students of the future.

Proceeding then with the demonstration, Dr. Doyen remarked at the outset that as he was addressing surgeons, the demonstration would be more summary and less detailed than if he had been explaining his technique to students. The method followed in showing each operation was by first projecting a certain number of fixed slides showing consecutively the instruments, &c., required, the various steps of the operation one by one, and second, following this up by showing the operation in entirety as recorded by the cinematograph.

I. Fourteen slides showing the steps in an *ovariotomy* and the details in the use of Doyen's lever-clamp forceps:—

Incision and opening of abdomen.	The lever open.
Incision of cyst.	The forceps closed.
Evacuation of cyst.	The lever opened.
Cyst drawn out.	The lever released.
Examination of pedicle.	Clamping effect of forceps.
Pedicle clamped.	Ligature of pedicle.
Crushing forceps applied.	Section with thermo-cautery.

A complete cinematographic representation of an *ovariotomy* was then shown.

II. Twenty-four slides were then shown illustrative of Dr. Doyen's method of *abdominal hysterectomy*:—

Operating-table in Trendelenburg position.	Section to right of cervix.
Instruments required.	Section to left of cervix.
Further instruments required.	Forceps on uterine arteries.
Abdomen opened, forceps in vagina.	Cervix entirely free.
Tumour raised with corkscrew.	Right broad ligament sectioned.
Section of left broad ligament.	A complicated case, adhesions.
Neither ligament cut.	Same case.
Both ligaments cut, in order to reach cervix.	Orifice of vagina, after cervix was cut.
Cervix seen through opened vagina.	Suture of peritoneum begun.
Incision of posterior cul-de-sac.	Suture of peritoneum completed.
Cervix seized by tenaculum.	Peritoneum closed. Simple case.
Cervix drawn up.	Peritoneum closed. Complicated case.

Cinematographic reproductions of three abdominal hysterectomies were then shown.

The first, taken December 8th, 1899, by artificial light. The second, a case of multiple fibroids with adhesions. The third, showing the suture of the peritoneum completed; all therefore showing the same general method of operating applied both to simple and to complicated cases.

III. Thirty-eight fixed slides were then shown illustrating the technique in *Vaginal Hysterectomy*—

Operating table, special leg pieces.	Extraction of uterus.
Instruments required.	Extraction of left appendages.
Further instruments required.	Forceps on left broad ligament.
Drawing of relations of uterus.	Drawing of same step.
Cervix drawn down.	Section of left broad ligament.
Incision posterior cul-de-sac.	Same from photograph.
Scissors opening Douglas' pouch.	Forceps on right broad ligament
Exploration with finger	Section of right broad ligament.
Incision of anterior cul-de-sac.	Toilet of the peritoneum.
Drawing of relations of uterus at this stage.	Forceps left on broad ligaments.
Cervix drawn down.	Left broad ligament clamped.
Isolation of bladder.	Right broad ligament clamped.
Bladder pushed aside with finger.	Ligature
Diagram of this stage.	Toilet of peritoneum with compress.
Right broad ligament clamped.	Aspect of vulva after operation.
Left broad ligament clamped.	Hysterectomy for fibroid.
Anterior median section of cervix.	Extraction of large fibroid.
Opening of anterior peritoneal cul-de-sac.	V-shaped incision.
	Uterus drawn out at vulva.
	Extraction of a cyst above uterus.

Four vaginal hysterectomies were then shown as they had been recorded by the cinematograph, showing the possibility of demonstrating to hundreds what half a dozen could not see so well in an operating theatre. After the gynecological demonstration, Dr. Doyen showed, at the request of the president, a cinematograph of a nephrectomy, and incision of a goitre. In conclusion, Dr. Doyen thanked the members for their courtesy and attention, and begged to assure them of the sympathy of French scientific men for their English brethren and for the English nation. Dr. Doyen's lecture on the subject will be found at page 1.

Dr. C. H. F. ROUTH, who spoke in French, said:—Monsieur le Président et mes confrères,—C'est un privilège qui m'a été conféré de présenter nos remerciements bien sincères et bien mérités à l'illustre professeur, M. Doyen, qui est venu vous voir de la France pour nous charmer avec une lecture illustrée par le cinématograph sur les opérations gynécologiques, pratiquées par lui-même à Paris et autre part. De faire cette traversée à cette saison, n'est pas très agréable en hiver, surtout lorsque le temps est aussi orageux qu'il l'a été dernièrement. Mais l'amour de la science l'a inspiré à faire ce voyage, et ce soir nous avons eu un très grand plaisir, une instruction parfaite, que nous n'oublierons jamais. Une instruction nouvelle, et qui, avec la lanterne magique, nous a permis de voir toutes ces opérations comme si nous avions les personnes elles-mêmes devant nous. C'est donc un très grand privilège d'avoir non seulement entendu cette superbe lecture, mais de voir M. Doyen opérer devant nous, et suivre par la photographie chaque mouvement de ces mains agissant avec tant d'aise et si exactement. En plus vous savez tous que M. Doyen est un opérateur très distingué parmi même tous les maîtres de la gynécologie chirurgicale. A Paris il est reconnu comme chef dans son art, mais le nom de Doyen est connu partout aussi. La France entière lui fait honneur dans les premières places. Allez où vous voulez, en Angleterre, en Amérique, en Allemagne, en Russie, en Asie, aux Indes, en Afrique, même dans les parties du monde les plus éloignées, comme l'Australie, il est connu, honoré, et apprécié. C'est un citoyen du monde tout entier, et un des plus fameux chirurgiens. Ce que j'ai remarqué dans ces illustrations, c'était la rapidité avec laquelle M. Doyen paraissait opérer. Ensuite chaque instrument préparé, arrivé au moment exact, point de retard, tout à temps, et succès complet de l'opération. Son aide-de-camp à son côté préparé à assister, la nurse à sa place toujours juste; et le chloroformiste marquant chaque mouvement de la malade avec exactitude; on pouvait partout voir que tout était arrangé en ligne, en un mot que M. Doyen était un parfait opérateur. Nous avons, donc, bien raison de remercier, M. Doyen à tout cœur. Nous éprouvons un sentiment de gratitude parceque nous avons entendu une lecture des plus charmantes, et qui nous a enseigné beaucoup. Un autre sentiment c'est celui d'admiration d'un chirurgien si célèbre. Au nom donc de notre distingué Président, et de celui de chacun parmi nous, nous désirons publiquement le remercier avec le plus grand empressement

de reconnaissance et de ravissement satisfait qu'il nous a fait grand honneur en venant parmi nous, et que nous avons écouté et apprécié sa lecture avec le plus grand plaisir.

Mr. SPANTON, in seconding the vote of thanks to Dr. Doyen, observed that one of the pleasantest features of scientific life is the welcome accorded to foreign scientists; and on this occasion the society might deem itself fortunate in having so distinguished a surgeon as Dr. Doyen among them. The exceedingly beautiful and brilliant cinematographical representations had been so well described by Dr. Doyen that it was quite easy to follow every step in the various operations shown; but he thought they ought to bear in mind that an operation so shown and described by one surgeon may be a very very different matter to the same operation performed by another surgeon. Dr. Doyen had initiated a new mode of demonstration which had a great future before it; and Mr. Spanton felt that he was expressing the feeling of all present in saying that the Fellows were greatly indebted to Dr. Doyen for his delightful address, to which everyone had listened with the keenest interest, and in the name of the provincial Fellows more especially, he seconded with the utmost pleasure the vote of thanks so admirably proposed by Dr. Routh.

Dr. GODSON said:—"May I be permitted as a past president to say a few words to express my accord with all that has fallen from the lips of Dr. Routh and Mr. Spanton, and my sense of the deep obligation our society is under to our distinguished Honorary Fellow for having come over from Paris to give us such a pleasing demonstration. To all of us Dr. Doyen has long been known by repute as the king of hysterectomists, and many of us have longed for the opportunity to see him operate. Thanks to the realistic character of the living pictures which he has shown us this evening, I feel sure there is not one of us who will go away this evening without feeling that he has been present at Dr. Doyen's operations, that he can testify to his extraordinary dexterity and skill from what he has himself witnessed, and that he has learnt some useful lessons. I am glad of this opportunity of personally thanking Dr. Doyen for his kindness."

THE PRESIDENT, in conveying the vote of thanks to Dr. Doyen for his most interesting demonstration, said that those who had seen it must remember that these operative methods had not been quickly achieved, but had been arrived at by a true evolutionary process in the progress of gynecology within the last few years. He pointed this out in the various modifications of operative procedure in abdominal and vaginal hysterectomy in which Dr. Doyen himself had played a considerable part. It was one thing, Dr. Doyen performing the operations as he had demonstrated them, it was another that those who were unacquainted with such procedures should go away and fancy they were as simple as they appeared in his hands. If they tried to put this belief into practical effect they would find themselves in a very awkward position. Dr. Doyen was not only a distinguished gynecologist, but he was also one of the most brilliant of French general surgeons, and the Society was proud of the fact that he had been for some time one of its Fellows. On its behalf he tendered to him the warmest thanks for the brilliant demonstration he had given that evening, and for the trouble and pains he had taken in bringing from so great a distance all the necessary apparatus, as also for the special films which he had prepared to show to the Society.

ROYAL ACADEMY OF MEDICINE IN IRELAND SECTION OF MEDICINE.

MEETING HELD FRIDAY, DECEMBER 15TH, 1899.

The President, Dr. J. W. MOORE, in the Chair.

DR. J. LUMSDEN exhibited a case of "Pseudo-hypertrophic Muscular Dystrophy."

Dr. O'CARROLL read a paper on "The Pulmonary Second-sound," and dealt chiefly with the significance of

accentuation of the second-sound in the pulmonary area.

Dr. LANGFORD SYMES read a paper on "The Examination of Sick Children," which we published in our last week's issue.

In the discussion which followed, Dr. DOYLE said that very often in examining sick children it was necessary to resort to an anæsthetic, as he experienced in a recent case of his of hæmorrhage from the bowel. On making a rectal examination under chloroform he discovered a polypus, which was subsequently removed. One of the first things he would look to was the condition of the mouth and pharynx, and all the openings of the body. The possibility of feigned disease should always be borne in mind.

Dr. O'CARROLL said that, as the previous speaker had hinted, the complaints of children might in many cases be due to the suggestive influence of the parent. Children were also quite as liable to hysteria as adults. He did not consider reflexes of much value in examining children under two or three years of age, as the lateral tract was then ill-developed. He emphasised how important it was for a young practitioner to know the times of temporary and permanent dentition.

The PRESIDENT said that it was necessary to gain the confidence of the child before laying a finger on it. He was, therefore, inclined to criticise the recommendation about undressing the child in an out-patient department.

Dr. SYMES, in reply, alluded to the lack of properly organised teaching in diseases of children, and thought that the subject should no longer be neglected. The frequency of disease, its high mortality, the strangely different diseases which are peculiar to children, and, above all, the advantage of the study as a training ground for senior students, combine to strongly recommend it as a most profitable course for the fifth year.

The Section then adjourned.

LIVERPOOL MEDICAL SOCIETY.

MEETING HELD DECEMBER 21st, 1899.

Dr. MACFIE-CAMPBELL, President, in the Chair.

GRATUITOUS ATTENDANCE OF THE FAMILIES OF RESERVISTS.

The following resolution was moved by Dr. J. MOORE DAWSON, seconded by Dr. J. J. O'HAGAN, and carried.

"Owing to the fact that the present war in South Africa has necessitated the calling out of our reservists and volunteers for active service, many of whom have left behind them wives and families in straitened circumstances, we, the members of the Medical Institution, are willing to give our professional services gratuitously to the said wives and families, provided that the cases are authenticated by some recognised authority, and that our services do not interfere with the relations of such families and their present medical attendant."

Dr. CARTER read a note on "Digestives."

Dr. GRIMSDALE related a case of "Fibroid Tumour of the Uterus," causing ascites. The patient was a frail old woman of 67. She had known of the tumour for years. The menopause occurred at 50. For 12 months or so her abdomen had increased much in size so that she had much difficulty in getting about. The abdomen was tense, skin shining, girth measurement 40 ins. Solid tumour could be felt in the fluid. The diagnosis of uterine tumour was easy. The abdomen was opened, two gallons of straw-coloured fluid released from peritoneum. Hard solid tumour nearly as large as the adult head was removed, its attachment to the uterus was two inches by half an inch. This was sewn up with the continuous suture and abdomen closed. Patient made a good recovery. The points of interest were the advanced age of the patient at which it was necessary to remove a uterine fibroid; the occurrence of a large amount of ascitic fluid with a simple uterine fibroid; the roughened surface of the tumour, which had evidently irritated the peritoneum by friction.

Dr. MACALISTER related two cases of "Chronic Paren-

chymatous Nephritis," with the results of prolonged treatment in the Home for Incurables.

Dr. GEMMELL read a paper on

ECTOPIC PREGNANCY.

Taking as a basis of classification that all cases were primarily tubal, he discussed the changes taking place in the peritoneum, muscle and connective tissue of the tube, following the impregnation of the ovum, noting particularly the change in the abdominal ostrum during the first four weeks, and its patency, up to the eighth week, as predisposing to tubal abortion, rather than to rupture of the tube. The uterine deciduum was described, with the characteristic points distinguishing it from an early uterine abortion. Cases were related, and drawings and lantern slides exhibited of the specimens from several recent cases upon which he had operated, illustrative of the termination of tubal pregnancy (a) by destruction of the fetus, or (b) by rupture, extra and intra-peritoneal. The formation of the tubal mole, its analogy to the uterine molar pregnancy, the lamination of the clot and eccentric position of the ovum were noted, and cases of tubal abortion, partial and complete, related. The destruction of the embryo by hæmato-salpinx and pyo-salpinx was questioned. The great essential of accuracy in diagnosis of these cases was the finding in the blood clot or *debris*, microscopic evidence of gestation—viz., chorionic villi and decidual cells, and the very nature of the process of suppuration and degeneration of blood-clot proves the only trustworthy information. Two of his cases he hesitated to class as tubal pregnancy destroyed in this way, for the reason that whilst the clinical evidence was complete, the microscopical was absent. Extra-peritoneal rupture occurring into the meso-metric tissue was the most favourable termination, limiting the hæmorrhage to a broad ligament hæmatoma, and rarely requiring operation. Of the cases of intra-peritoneal rupture the most interesting was one in which the gestation sac with blood clot and placenta, was found in the abdominal cavity, above the uterus, the fetus extruded from the sac, and undergoing mummification, lying between the sac and the abdominal wall. The left tube was cicatrised and blocked at its middle third, and on microscopic examination, proved to be young fibrous tissue being evidently scar tissue. Dr. Gemmell believed this to have been a tubal gestation which had ruptured and extruded the fetus and membranes as a whole, the sac then forming adhesions to surrounding structures, and becoming abdominal. The variations and in many instances want of symptomatology, were referred to; and the treatment described as expectant and operative, the latter being preferred as being in accordance with surgical principles, and with aseptic methods, was eminently satisfactory. Dr. Gemmell had only operated in these cases by the abdominal route, and in the choice of time for operation preferred to wait for the primary collapse to pass off, or in urgent cases, to use an intra-venous saline injection at the time of operation.

Drs. WILLETT, J. J. O'HAGAN, GRIMSDALE, and BUCHANAN took part in the discussion. Dr. GEMMELL replied.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD AT OWENS COLLEGE, MANCHESTER, DECEMBER 17TH, 1899.

The President, Dr. DONALD, in the Chair.

SPECIMENS.

Dr. J. E. GEMMELL (Liverpool) showed a fetus and placental sac from a case of abdominal pregnancy. The mass was removed by abdominal section, the patient making a good recovery. Microscopic sections of the Fallopian tube were shown. The rupture had occurred close to the uterine end of the tube, and the placenta had developed mainly in the expanded and everted Fallopian tube.

Dr. J. B. HELLIER showed (1) a uterus with multiple fibroids and double pyosalpinx removed by pan-hysterectomy carried out by the "combined" method. The patient made a good recovery. (2) A case of vesicular disease of the great omentum.

Dr. D. LLOYD ROBERTS showed a cyst of the kidney the size of an adult head. The tumour was successfully removed by abdominal section.

The PRESIDENT (Dr. Donald) then gave a Presidential address, entitled "Minor Gynæcology."

In reviewing the changes which had occurred in the practice of minor gynæcology during the last fifteen years, he dwelt especially on the following four points: (1) The use of pessaries; (2) the use of the uterine sound for diagnosis and treatment; (3) caustics and other irritants in the treatment of cervical catarrh; and (4) the methods adopted in out-patient practice for the management of minor gynæcological ailments. He thought that there was considerable divergence in our practice from that which prevailed widely in the early eighties.

SOCIETY OF ANÆSTHETISTS.

Dr. J. FREDK. W. SILK, President, in the Chair.

IMPROVED METHODS IN ANÆSTHESIA.

At the last meeting of the Society the PRESIDENT read a communication from Mr. Walter Edmunds describing a paper inhaler for use with Junker's apparatus for the administration of chloroform, the object being to use a new paper to every case.

Mr. COPESTAKE (Derby) read a paper on "A New Inhaler for Ether, Chloroform, or Mixture," the face-piece of which was made of celluloid.

Dr. FLUX read a paper on a small contrivance for use in the administration of chloroform. A small metal cylinder was attached at the upper end to the inlet of a ball bellows, the delivery tube of which led directly to a face-piece. The cylinder contained cotton wick, and chloroform was poured on it through the lower open end. The instrument was light, portable and easily managed, and possessed the advantage that both the strength and the amount of the mixture were absolutely under control.

A discussion followed, in which Mr. Rickard Lloyd, Mr. Carter Braine, Mrs. Dickinson Berry, Mr. Edgar Willet, Dr. Dudley Buxton, and the President took part, the consensus of opinion being that the suggested improvements were unreliable and difficult of application.

Mr. MCCARDIE read notes of a case of respiratory and cardiac failure during administration of chloroform to a patient probably of so-called lymphatic diathesis, and Mr. RICKARD LLOYD narrated the facts of a case which was under his care.

The President, Dr. Dudley Buxton, Mr. Carter Braine, and Mr. Grant Morris took part in the discussion which ensued, and Mr. McCardie and Mr. Rickard Lloyd having replied, the President concluded the meeting by announcing that on February 2nd the Society would discuss the sequelæ of ether and other anæsthetics more especially with regard to pulmonary complaints.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, December 30th, 1899.

At the last meeting of the Free Society of Surgeons, Hr. Reichard reported on

THREE CASES OF PARENCHYMATOUS GASTRIC HÆMORRHAGE,

in which at the autopsy no other disease was found that could clearly explain the origin of the hæmorrhage. The first case was that of a man who for several months had been jaundiced, and who showed all the signs of

chronic closure of the choledochus. Laparotomy was performed, the gall-bladder and bile passages were dilated, but no stones were found. Hr. Lindner, the operator, did a cholecysto-jejunostomy; the operation was simple and did not last long. For five days the patient did well, but on the 6th excessive hæmorrhage took place from the bowel, and again on the two following days, and the patient died on the 8th. The autopsy showed the stomach and the whole of the intestines filled with blood, but no visible source of it was anywhere found. The papilla of the duodenum were embedded in a fibrinous mass that pointed to carcinoma. Although the hæmorrhage was favoured in this case by the jaundice, it was not so in the two others. These were two young women, who were admitted into the Augusta Hospital with symptoms of grave anæmia from hæmorrhage from the stomach. One of them had a typical history of ulcer, and she was transferred to the surgical side for operation. Vomiting of blood took place even whilst the patient was on the table. Laparotomy was performed; the stomach, which was filled with bloody mucus, was opened and palpated, but no source of the bleeding was found. The stomach was tamponaded with sterile gauze, and a tube introduced into the duodenum for feeding purposes. The hæmorrhage did not return, but the patient soon died of the persisting anæmia. On section an old cicatrix was found on the lesser curvature of the stomach, but no ulcer.

The other patient had a similar history, and several times when in hospital had hæmatemesis. Laparotomy was performed, and the stomach opened, blood was found in it, but no visible source of it. Death took place in this case also, and section showed no erosion of vessels.

Hr. Ewald said he had known such cases for a number of years. They were to be distinguished from those in which stasis from cirrhosis of the liver favoured hæmorrhage.

Hr. Rinne related a case of

SPONTANEOUS RECOVERY FROM TRAUMATIC RUPTURE OF THE URETER.

The patient from whom the preparation was removed had a gynæcological operation performed only two years previously, during which the operator had the misfortune to cut a ureter across. He made an attempt to repair the damage by suture. For two days the whole of the urine came away through the bladder; after that a part came through the abdominal wound. When the patient came to him she was suffering from severe sepsis; there was pus in the pelvis and an urinary fistula in the abdominal wound. He first of all drained the purulent collection through the vagina, and soon urine began to come that way, and on measuring it the quantity was found to equal to that coming through the bladder. The abdominal wound closed, but the fistula remained in the vagina. After the patient had recuperated somewhat, an attempt was made to get at the ureter extra-peritoneally, but only the central end could be found; the peripheral end could not be traced. The central end could not be implanted in the bladder. The speaker then decided to extirpate the kidney, but before that could be done collapse came on, and the operation had to be deferred. Gradually the discharge of urine through the bladder became less, and one day it ceased altogether. For three weeks the whole of the urine came through bladder, when the abdominal wound opened again, and

urine escaped from it. This continued for fourteen days, when the urine again came altogether through the bladder, and from that time continued to do so.

The patient from that time showed no symptoms of mischief arising from block of the urinary tract.

In November of this year, she again went into hospital with uræmic symptoms, from which she died. Double-sided renal calculus was found to be the cause. The cut ureter had united spontaneously, and was quite permeable.

Hr. Israel read a paper

EXPERIENCES IN DISEASES OF THE PANCREAS.

He said that although cysts of the pancreas, with the exception of those developing in the tail part, and of those with pedicles, were quite immovable, he had observed one belonging to neither of the above categories, which was as movable as a wandering kidney. A woman in the thirties began with headaches and pains in the stomach, which latter sometimes amounted to colic, with vomiting and increasing weakness. On examining in the dorsal position he found a slightly prominent tender and tense elastic tumour under the left ribs. It was about the size of an orange, and when she lay on the right side it sank to that side and could be felt over its whole circumference. When the stomach was empty it could be felt plainly, when full only a small segment could be distinguished.

Laparotomy was performed. After separation of the gastro-hepatic ligament, he came upon the cyst, which was covered with fibrous and glandular structures. These were ligatured and separated in sections, the tumour exposed and removed. It was then seen that the whole pancreas possessed such liberty of movement that it could be drawn out of the abdominal opening. The contents of the cyst were a slightly turbid fluid that changed sugar and emulsified fat. Recovery was uninterrupted.

In another case a cyst of the pancreas had been mistaken for intermittent hydronephrosis, with attacks of pain at intervals of some weeks, the tumour disappearing after the attacks, which generally lasted six days. Finally the attacks became more frequent, but distinct intervals of freedom still remained, although shortened. There was a tumour behind the stomach, as shown by blowing up of this which moved very freely on respiration.

On laparotomy the tumour was found covered by the gastro-colic ligament, and closely attached to the colon. In separating the attachments the cyst ruptured, and in consequence could not be removed *in toto*, but had to be sutured. The fluid which escaped did not possess the ferment properties of ordinary pancreatic cysts. The fluid continued to escape from the wound for 18 days, when the opening began to close. The case was important as showing that exploratory puncture might not yield a fluid corresponding to what would be expected from such a cyst.

Sometimes exploratory puncture alone, of such a cyst resulted in permanent recovery, as shown in one of his cases. The fine needle passed through both walls of the stomach, and did no harm. This was five years ago, and the man had had no return of trouble. Possibly a calculus of the pancreas had been the cause of illness.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, December 30th, 1899.

A NEW TRAUMATIC SPINAL DISEASE.

At the "Doctoren Collegium" last week, Schlesinger repeated his convictions of having discovered a new disease resembling, as he admits, Marie's "Spondylorhizomelique" but, not exactly coinciding with it. After rehearsing all the diseases and authors on the subject of traumatic affections of the vertebræ, he made a differential diagnosis of his new disease that many of the members could not accept. Becteren's disease, he said, differed from his in having a rheumatic origin, while an infection was to be traced to the primary cause of Strümpel and Marie's cases. In Strümpel's an hereditary tendency with individual disposition could be perceived. Another marked difference in the Strümpel-Marie cases was the progress of the ankylosis from below upwards. He would not press this as a constant in the symptoms of the disease, as he had seen cases progressing in the same order.

In the post-mortem room no difference in the "Wirbelversteifung" can be observed. In all the ligaments of the vertebræ ossified, particularly the ligamentum flava and ligamentum apicum. The articulations of the vertebræ are also changed, but if a fresh specimen before maceration be carefully examined, arthritis deformans can easily be diagnosed. He finally admitted that the principal differences in his cases were to be found in the ætiology, distribution, and course of the disease.

Kümmel's cases of spondylitis traumatica were here brought under notice, which he said differed from his own in having the phenomena of shock, after which came a stage of latency followed by motor and sensory paralysis; yet, grave as these symptoms appear, recovery is frequently recorded, which have led to the conclusion that Kümmel's disease is tuberculous in nature, though immediately excited by an injury. However, from the diversity of symptoms recorded in the cases reported Schlesinger is inclined to believe in several diseases being blended in Kümmel's spondylitis traumatica which are not properly isolated.

It has been suggested, Schlesinger said, that the cases I have reported are some form of traumatic spondylitis tuberculosa, or probably a carcinomatous condition in which there may be some truth as it is possible that an injury where such a predisposition exists may localise the tuberculosis, or induce a neoplastic condition, but before we admit this conclusion we must first discover the tuberculous tendency which does not exist in the cases I have reported; neither does radiography assist us in such a conclusion.

OVARIAN TRANSPLANTATION.

At the Gesellschaft Knauer reported the results of his experiments on guinea pigs in which he had transplanted thirteen ovaries. (a) He found that when the ovale was extirpated and placed in a fold of the mesometrium or between muscle and fascia, the animals made excellent recoveries; (b) that the transplanted ovaries three years later were healthy and active functionally, and several of the cases when impregnated at that late period produced three normal young animals, and

no alteration could be observed by the operation. In eleven of the cases, however, the ovaries healed up perfectly, but were somewhat badly nourished, while the uterus and mammae became atrophied.

The Operating Theatres.

GUY'S HOSPITAL.

TWO CASES OF SUPPURATING KIDNEY. FIRST CASE TREATED BY EXCISION. SECOND CASE TREATED BY INCISION AND DRAINAGE.—1st. Mr. ARBUTHNOT LANE operated on a fat woman, æt. 65, who had a large tumour in the right loin, clearly nephritic, and giving a history of a discharge of pus at frequent intervals in the urine. It would appear that the condition was one of pyo-nephrosis, originating in the kinking of the ureter in a very mobile kidney. The sensation given to the finger by the tumour, and the length of time during which it had existed, suggested very considerable destruction of the secreting substance of the kidney. The tumour was exposed by means of a long oblique incision, which extended through the loin forwards and downwards on to the abdomen. On cutting into the tumour there was very little kidney substance to be seen in its wall, and as the quantity of pus contained in it was abundant, it was decided to make an attempt to shell it out from its peritoneal surroundings. This entailed much time and trouble, especially in the removal of that part that extended up beneath the ribs. Stout ligatures were then placed round the pedicle, most of the wound closed and the interval filled up with iodoform gauze. Except for a good deal of chronic bronchitis which necessitated her being placed in sedentary posture in bed immediately after the operation, the convalescence was satisfactory and she has now left the hospital. The second case was that of a woman, æt. 35, who suffered from a tumour in the right loin, also renal in origin, and clearly starting in a movable kidney, whose mobility had followed rapid loss of flesh after a confinement. In her case the chief symptom was pain associated with the intermittent passage of quantities of very foul urine in which there was a variable amount of pus. The sensation given by the tumour to the fingers, together with the comparatively short history of the case and the amount of pain experienced during each attack, suggested that there was a considerable quantity of secreting substance left; this encouraged Mr. Lane to hope that by draining the kidney, which would now be fixed in its normal position by the inflammatory process going on about it, the passage might be restored and the remaining kidney substance saved to the patient's permanent advantage. Events turned out precisely as he had hoped. After cutting down on the kidney the wall was found to be thick and to contain much kidney substance. It was drained, and although an abundant discharge took place for some time, it was rapidly reduced in quantity, and at present a sinus alone remains, almost all the secretion from the kidney passing into the bladder. Mr. Lane said he could not protest too strongly against the custom which has arisen among many surgeons of removing hydro or pyo-nephrotic kidneys indiscriminately without making a determined effort to save them. He had known patients exposed to the risk entailed from the operation, and deprived of a considerable quantity of good secreting

material, which he believed could have been saved by more conservative and skilful methods of treatment. Surgeons are often, he said, too apt to trade on the knowledge that life can be carried on by a fraction only of the secreting substance normally provided, and too readily have recourse to the clumsy method of excision rather than fall back upon the various means that may be adopted for re-establishing a free passage between the pelvis of the kidney and the ureter. He had no doubt that a very large proportion of cases of hydro-nephrosis were consequent upon an abnormal mobility of the kidney, and this should, he thought, be taken into consideration in the treatment of movable kidney, in which there is evidence of obstruction, however slight and however intermittent.

ST. THOMAS'S HOSPITAL.

OPERATION FOR UNUNITED FRACTURE OF THE LEG.—Mr. BATTLE operated on the case of a man, æt. about 60, who had been admitted about three months before for compound fracture of both legs. The right one had become firmly healed, but the left continued ununited, although the wound had closed; the fracture was an oblique one about two inches below the middle of the shaft of the tibia, the fibula having been broken at a higher level. The wound had probably been made by the lower end of the upper fragment which was very sharp, and sloped from without inwards and downwards. There was free mobility of the lower part of the leg on the upper at the seat of fractured tibia, but movement on the outer side was at the level of the upper tibio-fibular joint. The limb was of course shortened. After the leg had been thoroughly cleansed and rendered bloodless an incision was made along the front of the tibia, and another inwards from the middle of this to the posterior edge of the same bone. It was then found that the upper end of the lower fragment had been forced under the muscles of the anterior part of the leg, and had become united to the lower end of the upper fragment of the fibula, the upper end of the lower fragment of the fibula was changed by the deposit of callus round it, but had not become united by bone. In order to reduce the upper end of the lower fragment of the tibia, it was necessary to deepen the incision by the side of the upper fragment, so as to permit of stretching of the muscles this incision was carried through muscle, so as to permit the attachment of tibia to fibula being divided; after this had been done and the muscular tissue with fibrous adhesions had been separated from the fragment to some extent an oblique section was made of the broken ends where they came into contact. Before this was done a piece of the upper end of the fibula required removal with a chain saw, so that it might be opposed to the lower end of the upper fragment. A screw was passed from without inwards through these, placed in contact, and, as one screw held them in position nothing further was put in. The bleeding points, which were not numerous, were secured, and the wound closed with interrupted fish-gut sutures. No drainage tube was used. The limb was afterwards placed in a Nevill's splint. Mr. Battle pointed out that although it was rare nowadays to find an ununited fracture of the leg that required operation, still this showed the usual combination found in a large percentage of ununited fractures, for the fracture had been a compound one in the first

instance, and there had been muscle interposed between the ends.

It is satisfactory to state that a fortnight after operation the patient was doing well, there having been no suppuration or interference with the circulation of the limb.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JANUARY 3, 1900.

THE PAST CENTURY.

To review the past century from a medical point of view is not an easy matter. We are taken back to the time when those who lived were influenced by the work of the Hunterian School; the brothers who set an example which the best men followed, and when in every department of art and science it was a time to be regarded with reverence and esteem. The influence of a great mind such as that of William Hunter's made itself felt. Truth above all things was the aim of those who were with him. It was not for fame or money that men worked, and it was not on the *vulgus profanum* that they relied for support. We pass from them to the next generation, when the troubles on the Continent were subsiding, and attention was being given to the discoveries of Humphry Davy, Wollaston, Jenner, Thomas Young, Matthew Baillie, and their friends. Pathology became of the greatest interest, and was resorted to for the aid it gave in understanding better the causes of symptoms observed during life. The physics of auscultation were brought over from Paris, and the work of Laennec was regarded with the deepest interest. There was no rush after ephemeral ideas in those days, though there was active contest when opinions differed. To the science of chemistry both medicine and surgery owed much. The separation of the alkaloids, morphia, quinine, and others, supplied the physician with valuable aid; while chloroform gave the surgeon an advantage which he was perhaps slow

in appreciating. Certain instruments by which the eye, the ear, and the throat could be examined, were the outcome of improved knowledge in optical science; and the improvements in the microscope enabled the pathologist to see how many morbid processes commenced, and which, without its help, the naked eye or ordinary lenses could not explain. The patient industry of Bright, the energy of Marshall Hall, the originality of Sir Charles Bell are not yet consigned to the pages of history, for there are some still living who remember them. In these days when biographies are the fashion, it is strange that very few appear of those who have worked as physicians or surgeons during the past century. The life of the traveller, and the actor or the politician will naturally interest the public more than that of the man of science; but this is to be regretted, for it is to science that all our progress is due. It is for the profession to show their appreciation of the men to whom they owe their knowledge, and not let their memories fade away. The public cannot judge of the merits of our best men in matters medical and surgical, and it is for the profession to uphold those who benefit it. There is no doubt but that during the last half century the great principle of antiseptic treatment is the most important addition to the art and science of surgery. In medicine the nature of those fevers which were the cause of serious trouble has been studied to much advantage, so that typhus and typhoid are no longer the cruel scourge of the people, and the principle that prevention is better than cure is now recognised most fully. In Sanitary work great reforms have been effected. The importance of proper drainage, and the supply of pure water is admitted on all sides. This practical work was the outcome of the labours of a few rare observers long before the middle of the Century. It would be well to be careful not to obstruct the progress of knowledge by too much devotion to the past. Let the Twentieth Century be commenced in a spirit of ready reception of the work that truly scientific men are offering, and let not the wild outcomes of investigation attract as they are liable to do from the straight and narrow path of Truth. Let the profession realise the duties it undertakes, and let it follow the example of the courage that our soldiers are exhibiting, while it is careful not to allow misguided enthusiasm to mislead.

THE CINEMATOGRAPH IN THE TEACHING OF OPERATIVE SURGERY.

WE are all familiar with the cinematograph as an instrument of amusement; as an instrument of scientific investigation, also, it has had its triumphs, notably in the analysis of the movements of animals. The practical application of the principle of moving pictures to surgical teaching is, however, a comparatively unexplored province, and to the eminent French surgeon, M. Doyen, is due the credit of originating and carrying out the idea. His first demonstration was in our own country, and will be remembered by all who were present at the Edinburgh meeting

the British Medical Association in 1898. The demonstration was repeated before the Third International Congress of Gynæcology and Obstetrics at Amsterdam in the summer of 1899. At the last meeting of the British Gynæcological Society a few days since, a third demonstration was given, and as the Society hospitably threw open its doors, many members of the medical profession in London had the opportunity of witnessing this most interesting new auxiliary to the teaching of surgery. Hitherto, students and practitioners had three ways of learning how to perform an operation; it could be read up in text-books, it could be practised in the dissecting room, and it could be witnessed in the operating theatre. It is a truism that even the best written description of an operation may be a very unsatisfactory guide to its actual performance; the steps of the process usually require to be seen in order to be properly understood. There are some operations of which a fairly satisfactory idea can be obtained by practice on the cadaver, notably the ligature of arteries, amputations, excisions, &c.; but abdominal operations belong to a different category, since in most cases the performance of the operation on the dead body can teach nothing beyond the incision through the parietes. Therefore for this class of cases the operative surgery class-room is practically useless; and the third way has hitherto proved the only way of learning how to perform them. But those who have diligently followed this course, who have strained on tiptoe trying to catch a glimpse of the operator, over the shoulders of more favoured spectators in front, who have been jammed by less favoured spectators behind, or who have found themselves looking on from the sixth row of a gallery, know full well that this way of learning surgery is better in theory than in practice. Scores of onlookers can see the tumour or the limb borne away in a basin after its removal; about three persons can see the steps of the operation in such a way as will enable them to go away and do the operation themselves, and those three are usually the surgeon's assistants. With the cinematograph it is otherwise; during the progress of the operation the instrument comes under the "most favoured" clause, and is placed in such a position as to get a perfect view of the whole operation, and when its impressions are faithfully reproduced lifesize on a screen, the operation as originally performed can be witnessed by hundreds. *A priori*, then, we might expect the cinematograph to prove a really valuable addition to the equipment of a class for the teaching of practical surgery, especially when dealing with abdominal and gynæcological operations. This is the claim made for it by M. Doyen and those who have seen his admirable demonstrations will grant that his claim is well-founded. We shall not be surprised to see some of the larger medical schools introduce this whilom plaything into their own classrooms, pressing it into the service of sound learning; nor can we doubt that in some cases it will have a less soporific effect on a warm summer's day than the soothing voice of the professor. M. Doyen boldly claims for the cinematograph other uses, to which we

can refer only in hushed whispers. He says that it may be used with advantage to show prospective patients what an operation is really like, in order that it may be shorn of its terrors when their own turn comes; further, and more astonishing still, it will prove most useful in showing this prospective patient the calmness, skill and rapidity with which Mr. So-and-so performs this operation, in contrast by inference with Mr. So-and-so, who is not up to date. But we must not pursue this fascinating train of thought. We have been specially favoured with Doyen's lecture and notes of his latest demonstration; these will be found in our present issue, and will doubtless afford our readers much food for reflection.

THE MODERN SURGERY OF GUNSHOT WOUNDS OF THE ABDOMEN.

AT the present moment when the eyes of the whole nation are turned to the war in South Africa, there is, perhaps, one feature thereof which claims more attention than any other, and that is the casualty list which from time to time is issued by the War Office. That this should be the case is only natural, seeing how largely the heart of the nation is bound up with those now fighting for Queen and country against the rebel Boers. But apart from the matter of sentiment, the same casualty lists have a close interest for the medical profession, inasmuch as this is the first occasion, upon an extended scale, in which the officers of the Army Medical Department have been called upon to deal with the wounds inflicted by modern weapons of warfare. Probably, therefore, when the medical history of this war comes to be written, a great many new facts will be forthcoming, and a good many theories exploded. *Apropos* of the harvest of facts which can be reaped from actual warfare, one example may here be mentioned, namely, the experience gained in the late Hispano-American war in respect to gunshot injuries of the abdomen. An interesting paper upon this subject was read last month before the Southern Surgical and Gynæcological Association at New Orleans, by Dr. Grant, of Louisville, in which the experience of the surgeons gained during the war is reviewed. The lessons which that experience teaches is significant. In the first place, Klemm's analysis of 152 cases shows that in nearly all of those in whom penetrating wounds of the abdomen were established, who did not die of immediate effects, eventually succumbed to exhaustion from sepsis, and later, from suppuration; that is to say, as a rule, the only chance of saving life after penetrating gunshot wounds of the abdomen is to operate, for otherwise the victims will either die of hæmorrhage, peritonitis or sepsis. In further proof of this statement the author points to Parkes' statistics, which show the undoubted advantages of operating early in such cases. A study of Parkes' tables renders manifest such variations in the mortality succeeding complicated and uncomplicated wounds of the various viscera, all

of a fatal character without operation, as to indicate that in uncomplicated wounds in some situations the early operations will save from seventy-five to eighty per cent. of what would otherwise be fatal cases. The necessity, then, and urgency of early interference in gunshot wounds of the abdomen seems to be one of the lessons taught by the Hispano-American war, and the experience is such as to bear significantly upon the treatment of our wounded in South Africa. It has been pointed out that extravasation of the contents of the intestines is not so likely to occur in soldiers suffering from abdominal gunshot wounds, as in civilians, inasmuch as the former have generally been without food for many hours before receiving the injuries, and the intestines are consequently practically empty. But abdominal surgery is of necessity special surgery, requiring special skill, and it is hardly to be supposed that the majority of the officers of the Army Medical Department would feel themselves justified in attempting operative procedures of the kind, however necessary such procedures might happen to be. It is evident, then, that the Government should long ago have made preparations for a contingency of this nature by freely accepting the offers of well-known operating surgeons attached to London and other hospitals, which have been made. The announcement has just appeared that four more surgeons have been appointed to proceed to the Cape; but what are they "among so many" of our troops? At least forty and four would be nearer the mark.

Notes on Current Topics.

The War and the Medical Service.

A CORRESPONDENT of the *Times*, with the signature of "R. A. M. C.," points out that at the present moment practically the entire strength of the Royal Army Medical Corps has left the United Kingdom, thus placing the Government in the position of having no medical officers for the seventh and eighth divisions, now in course of mobilisation, to say nothing of the requirements of the Militia, Volunteers, and Yeomanry proceeding on active service. He also directs attention to two recent acts of the War Office, showing want of tact and opposition to the interests of the service. "Surgeon-General Nash, the late P.M.O., Netley, had to retire under the age clause on November 8th last. He could have been retained on full pay for any period up to two years, and he even offered to remain as P.M.O., Netley, after he was retired, and carry on the duties; but, no, he was turned out and another officer nominated to the charge. At the same time one of the ablest Surgeon-Generals in the service (Surgeon-General Evatt) was sent down to Devonport to take charge of the Western District, from which all the troops have been withdrawn." The correspondent also complains that the War Office have invited the retired officers 'liable to be recalled to service' to return to active duty, which means that instead of resuming their

former status in the service they are called upon to rejoin and serve under officers many years junior to themselves, besides losing their right to promotion and further pension. The Royal Warrant, on the other hand, lays down that such retired officers, in cases of national emergency, can be recalled and the opportunity afforded them of resuming their original places in the army list, and that all full-pay service, while so recalled, would count for further promotion and higher pension. These are only some of the ways which the War Office adopt to render the medical service of the army unpopular. But it is quite likely that the present "clique" at the War Office will find themselves arraigned before the nation after the present hostilities have ceased, both for sins of omission and commission, and then will be the time to show up their animus and spite against the Army Medical Department.

The Influenza Pest.

THIS dreaded disease has not only disappointed all hopes of its disappearance but has returned with greater vehemence than ever. It may be doubted whether any previous outbreak has attacked so many persons as the present, although, happily, the mortality has not been nearly so high as that met with in some of the earlier epidemics. Christmas Day all over the United Kingdom was more or less blighted by the advent of this unwelcome visitor, and in many cases both guests and hosts rose from bed to keep their dinner engagements. The unwisdom of such a proceeding, especially in such inclement weather as that which characterised Christmas Day, cannot be too strongly insisted upon. Yet we doubt if many of the foremost offenders have not been medical men, whose disregard of influenza is not a little remarkable, considering their knowledge of the course of the disease. As everyone should know by this time, a slight attack of influenza is just as dangerous as a sharp one. The average individual is absolutely safe if he stay warm abed, but if he go about his condition is at once shifted from security to danger. These facts have been demonstrated again and again until they are mere household maxims in ordinary medical practice. The infectiousness of the disease was well illustrated by the remark of a chemist, who said that when he got one prescription from a large household he knew that sooner or later he should send physic to every one else in the house, including the servants. There has been a famine of nurses, greater perhaps than has been experienced in any previous outbreak. Another feature has been the number of members of hospital Staffs attacked by the malady, so that many institutions have been for a time almost entirely deprived of the services of their resident and visiting Medical Staffs. In one case the popular surgeon of a London Hospital was married to a lady who actually left the sickroom, where she had been kept by a sharp attack of influenza, to attend the church. What between the "flue" and the war at the Cape, the Christmas season has been anything but festive.

Enteric Fever at the Cape War.

NOT the least of the serious questions that have been raised by events at the Cape with regard to army medical administration is the large number of deaths from enteric fever. In a properly administered army service, even on campaign, the disease should be almost if not quite unknown. It is small excuse to say that sanitation is absent in many or most parts of South Africa away from the large towns. Typhoid fever is preventible, and is practically a water-borne disease. What steps have been taken to keep the infection away from an army invading an admittedly fever-stricken country? Have arrangements been made for guarding the water supply in every detail? Have tubular wells been plentifully distributed, together with means for sterilising stream and well water, and pocket filters of the Pasteur type? Unless these things have been done we should say the Army Medical Department has not adopted reasonable precautions to prevent enteric fever decimating our troops in this South African campaign. It is much to be feared, however, that the spirit of enterprise has been hopelessly dwarfed long ago in the Army Medical Department, whose entire reconstitution, with a full recognition of status and responsibility, is urgently demanded. It is with cholera and enteric fever in India as with enteric fever at the Cape. An Army Medical Department alive to modern scientific methods and allowed a tolerably free hand would, in neither place, have permitted pestilences to stalk, practically unchecked, through the ranks committed to their charge.

The Discovery of Scabies.

ALTHOUGH, as far back as the twelfth century Avenzoar described a disease of the skin characterised by the presence beneath the epidermis of animalcule resembling lice, so small as scarcely to be visible, which, he remarked, could be extracted by scratching the skin, the disease now universally known as scabies was, even as recently as this century, regarded as a constitutional affection associated with cachexia and inflammation. It appears, however, that Rabelais, who, though a doctor of medicine is better known as a political writer than as a physician, was well acquainted with the disease, and was perfectly cognisant of its nature, contagiousness and treatment. It is narrated indeed in his famous work that one of the ancestors of Pantagruel was "exceedingly expert in removing worms from the hands," and elsewhere Rabelais laments the death of a medical friend who died in consequence of his having accidentally wounded himself in removing one of these worms with a paper knife. The rediscovery of itch in France dates from 1835, when a medical student demonstrated to Alibert, incredulous, how in his native land of Corsica the peasants withdrew the parasite by the aid of a needle, a feat which he repeated in Alibert's clinic. In a recent monograph on the subject it is shown that the disease has been discovered and rediscovered some half-dozen times, at intervals of centuries. How often is this the case

with medical discoveries? The worst of it is that treatments which have been again and again discovered and dismissed as useless or injurious are from time to time once more brought forward only to excite and cause fresh disappointment. If contemporary discoverers would only take the trouble to consult Neale's Digest or the "Index Medicus" before launching their fancied innovations, they would often be dissuaded from encumbering medical literature with their "mare's nests."

Humidity and Disease.

THE quantity of water vapour contained in the air varies within very wide limits according to the temperature and the direction of the prevailing winds. It is, however, not so much the absolute quantity of water vapour in the air that exerts an influence on health as the proportion in relation to the saturation point of the air, in other words it is the degree of interference with cutaneous and respiratory evaporation that is of importance. Sudden and extreme variations in the proportion of atmospheric humidity exert a well-marked influence on the absorption, transmission, and reflection of heat, light, and electricity, and these variations affect in a marked degree the activity of the vital processes. According to M. Chiais, the proportion of water vapour has a pathogenic influence whenever it falls below five or six grammes per cubic metre, or rises above twelve to thirteen grammes. If the air contains less than five grammes the tendency is to diseases of the congestive type and the mortality returns are increased by maladies affecting chiefly the respiratory tract though this circumstance acts prejudicially on sufferers from chronic cardiac disease and enhances the tendency to cerebral congestion, apoplexy, &c., in the aged. If, on the other hand, the air contains more than fourteen grammes per cubic metre of water, the tendency is to inflammatory affections of the intestinal tract, gastro-enteritis, and the like. There is reason to believe that it is less the relative abundance of water vapour that tells than the occurrence of sudden variations, these variations placing the organism at a disadvantage, only the physiologically active being able to adapt themselves to the change.

The Bacteriology of Holy Water.

AN unscrupulous Italian bacteriologist recently took the trouble to obtain supplies of holy water from the *benitiers* of sundry churches in Turin and subjected them to bacteriological investigation. As might be imagined, in a country where personal cleanliness is not a very marked feature, he reaped a rich harvest of microbes. He describes the samples as "extraordinarily rich in mobile and immobile bacteria, infusoria and various animal and vegetable organisms." Guinea-pigs inoculated with the centrifugated liquid died, for the most part with symptoms of septicæmia, one, however, dying of tuberculosis. Not to be without a moral, our observer urges that steps should be taken to ensure the periodical cleansing of the recipients, and the passage of

a current of fresh water through them. How he imagines that water, even if rich in infusoria, could possibly prove injurious to the faithful by merely coming into contact with the skin he does not explain.

General Hospital Dentistry.

THE most obvious anomaly in the medico-educational system is the ostentatious neglect of some of the subjects which are manifestly most necessary for the general practitioner. Who ever heard of a candidate at examination being asked to pass a catheter, or to show how a leech should be applied, or to apply a cupping glass or even to put in a hypodermic injection? A practitioner may be sent out into the world without knowing how to adjust a head bandage or splint a broken clavicle, but not unless he is familiar with the latest views on the pathology of some disease (or to detail the symptomatology of exaltative monomania), neither of which he will probably ever see in a life time. This neglect of a speciality is, perhaps, more obvious in the case of dentistry than in that of any other of the requirements of the general practitioner. The first case he meets with is likely to be one of tooth extraction, and his attendance on such cases is measured by scores of hundreds in the course of the year. Where does he learn to operate? In an extern dispensary with a bundle of out-of-date old instruments and without any one to tell him even which tool is wanted for a particular tooth. He is, in his first or second year, let out on the unhappy sufferers from toothache, and is lucky if he manages to extract the offending tooth instead of breaking off its crown or splintering the alveolus. In this way he acquires, before his fifth year comes, some limited experience, while his patients' vile bodies are the only instructors from which he learns. It is always possible, no doubt, for him to pay a high fee and spend much valuable time in attending a special dental hospital, and, if time and money are of no importance, he will derive benefit from doing so, but the drilling out and filling of cavities and the making of plates and sets are not what he wants for general practice, and therefore the great majority of students never seek to be instructed therein. We say nothing of the tortures which the out-patients suffer under this method of instruction in dentistry. That is a negligible detail.

The Death-roll of Aged Persons.

DURING the past week or more the announcement of deaths in the daily newspapers has assumed an unusual proportion, and the most noticeable feature thereof has been the large number of elderly persons who have died. For example, during the first four days of last week the death column of the *Times* recorded the deaths of no fewer than ninety-one persons of upwards of seventy years of age, fifty-three of whom were eighty and upwards, and eleven were over ninety. It is impossible to doubt that the changeable and trying climatic conditions to which we have been subjected of late has had much to do with this death roll. Cold, damp, foggy weather is especially destructive to feeble old persons,

disposed to catarrhal attacks. A few of the octogenarians who have recently died may have succumbed to an attack of influenza, but it is worthy to note that the fatal cases of this disease have, so far, not been numerous during the pre-ent season.

"A Hero of the Red Cross."

IN our contemporary, the *Graphic*, of this week a full page engraving appears of a pathetic scene with the above description. A wounded soldier is lying on a stretcher on the field of battle. On his left hand side is a hospital assistant holding a tray of instruments; the surgeon is on the right of the patient just about to begin an operation. But he has been struck by a bullet, and the engraving shows him to be falling backward over the prostrate form of his patient. The hospital assistant has a look of horror and dismay upon his countenance, and his feelings can be readily imagined under the sad circumstances. The scene vividly depicts the risks to which officers of the Army Medical Staff are exposed during the present war. The Boers have been repeatedly proved to be no respecters of ambulance parties, and consequently the casualty lists of the large engagements already fought have always contained the names of medical officers who have been killed. At all events, at least three officers of the Army Medical Service have been shot dead while attending to their duties on the field of battle during the present war.

Pigeon Messengers.

IN country districts where the telephone is not as yet available, patients often find it very difficult to convey messages to the doctor's house in case of need. A French country doctor, it seems, has for some years past made use of carrier pigeons for the purpose. When he is in charge of a serious case at a distance he leaves one or two pigeons at the house by which means he is enabled periodically to receive information which will enable him to decide whether or not it is necessary to make a subsequent visit on the same or the following day. The trustworthiness and promptitude of these winged messengers appear to have left little to be desired, messages from a distance of seven miles arriving within from one-half to three-quarters of an hour. Pending the generalisation of wireless telegraphy it is possible that assistance may occasionally be derived from this novel method of "ringing up the doctor."

"The Dioptric and Ophthalmometric Review."

THE British Optical Association, whose president is Mr. John Browning, the optician, possesses a journal with the above title. It is, of course, devoted especially to the interests of the trade, and to those members thereof who seek to provide the public with spectacles independently of the ophthalmic surgeon. In a copy, therefore, of the journal in question forwarded to us by a correspondent, we were somewhat surprised to see an article contributed by a member of the profession, Dr. Clements Hailes, of the Bristol Eye Hospital. The subject of the article

is "Tobacco Amblyopia," a subject which we altogether fail to see can have anything to do with the trade of spectacle making. It is not usual for medical men to contribute signed articles to lay publications, and still less so to those which seek to pose as organs of professional opinion. We doubt not that Dr. Hailes has inadvertently fallen into the error of contributing a professional article to a trade publication, and, under these circumstances, it is not necessary to say anything more upon the matter. Perhaps the Ophthalmological Society will enlighten the medical world as to its position in relation to this Society, of which one of the members is, we believe, an examiner.

The Charity Organisation Society and the War.

WHATEVER may be thought of the principles upon which the Charity Organisation Society has been founded there can be no doubt whatever as to the unpopularity of the methods adopted by that body. Their latest feat has been to stir up the anger of the public by staying the hand of relief stretched out to the wives and families of soldiers who are gone to fight our battles at the Cape. Money must not be given to any such person, forsooth, until the Society has satisfied itself that the antecedents of the absent soldier have been without a flaw. The temper of the British public must break forth at once in a blaze of indignant protest against such mean and paltry censoriousness. By freely offering their lives in the present strait our soldiers have more than purged any offences of the order that apparently stinks in the nostrils of this pharisaical Charity Organisation Society. Besides, are innocent women and children to suffer for the past peccadilloes of their soldier fathers? It is to be hoped that no distribution committee will be influenced by any reports received from this officious society, unless it be to increase the grants forthwith of all who are thus singled out as the victims of a misdirected principle. The proceedings of the Charity Organisation Society have long been a rock of offence to the noble spirit of philanthropy that permeates Great Britain. To regulate indiscriminate alms-giving and to check active roguery is one thing, to persecute the poor with harsh severity, as though poverty and past offences were crimes, is another. A Parliamentary inquiry into the work, the revenues, the cost of administration and the achievements, past and present, of the Charity Organisation Society would be a not altogether unadvantageous step.

A Remarkable Escape.

DR. LIVINGSTONE, a district surgeon at Ingwavuna, Zululand, has arrived at Durban, and tells a remarkable story of his escape from a Boer commando which invaded Zululand, and effected his capture. The commando, which numbered 275, took possession of the magistracy, and cut the telegraph wires. The *St. James's Gazette* reports that the officials took to their heels and bolted into the bush, but Dr. Livingstone was caught. He stumbled unexpectedly upon the Boers, who promptly covered him with their

rifles, took his horse, rifle, and ammunition away from him, and marched him off towards Vryheid. Some of the Boers in the commando had been previously medically treated by Dr. Livingstone, and with these the prisoner was on fairly good terms. When the commando encamped for the night four men were mounted guard over Dr. Livingstone, but about midnight the prisoner, who knew almost every inch of the country, quietly rolled up his mackintosh and made a sudden rush for a neighbouring ravine. Before his astonished guards had thoroughly grasped the situation the prisoner had gained a good start; but the whole commando was soon in hot pursuit. In the darkness, however, Dr. Livingstone eluded all his pursuers, and made his way to a Kaffir kraal where he was kindly treated and provided with an escort and scouts. He eventually reached the Ingonia Magistracy in safety, purchased a horse, and made for the Lower Tugela, where he has been congratulated on all hands on his daring escape.

Surgical Millinery Again.

THE cuckoo patiently incubating the hedge-sparrow's egg is not a more interesting spectacle than the austere Council of the Royal College of Surgeons of England engaged in the hatching out of the millinery details of the famous "Member's gown." This garment, we are told, is to be appropriately constructed of "a black stuff (and nonsense)," and it is to have "a plain unlooped sleeve, and the facings are not to extend to the back or be more than two inches in the widest part." We put it to the Members of the College that they are publicly branded with ignominy by being compelled to wear an unlooped sleeve and a beggarly two inch facing, and we doubt not that the great gown riot will be resumed if the Council does not forthwith decree a looped sleeve. "Who dares this pair of boots displace, Must meet Bombastes face to face."

A New Method of Killing the Tænia Solium.

AN American practitioner has discovered a new way of ensuring the death of the tapeworm, viz., by injecting it with a solution of morphia. Obviously it is indispensable for the practicability of this method that the worm should have been unguarded enough to escape in part from the anus. When this is the case all we have to do is to apply a ligature and inject a solution of morphia into the remainder, whereupon the worm, as a whole, dies and is expelled within a short time. So far so good, but the process is perilously like that of putting salt on a bird's tail, and this drawback is likely to militate against general recourse to the method.

The Newest Stimulant.

AN inquest was held recently on the body of a woman resident in the North of Ireland, aged 30. She had driven from a distance on a very cold night, and finding no more agreeable calorifier in her house than some vitriol, took some of it mixed with water

and as she found the effects unpleasant she followed the dose with some laudanum which she happened to have and then incontinently died. Apparently the pharmaceutical schoolmaster is not abroad in the North of Ireland.

THE West London Medico-Chirurgical Society have arranged to devote the February meeting of the Society to a discussion on syphilis, which will be opened by Mr. Alfred Cooper, F.R.C.S. Visitors, introduced by members, will be welcomed by the President and Council, and will be invited to take part in the proceedings.

THE Executive of the Dublin Port and Docks Board has appointed a committee to advise as to the future arrangements for the duties of Medical Officer to the Board vacated by the death of the late Mr. Hamilton. It is scarcely needful to observe that there is a wide and close competition for the position, which is a fairly lucrative one.

A TRANSATLANTIC hygienist calls attention to the danger to the public health entailed by the practice of waving handkerchiefs on occasions of public excitement. At a recent popular reception given to President McKinley he estimates that there were 20,000 persons, of whom at least 4,000 were tuberculous, and he wisely declines to form even an approximate estimate of the myriads of tubercle bacilli that the ovation must have been the means of setting afloat.

PERSONAL.

By invitation of His Excellency, Sir William Stokes had a farewell interview with the Lord Lieutenant of Ireland before leaving for South Africa last week.

THE Royal Society having selected Drs. Stephens and Christophers, who have recently returned from Central Africa, to serve on the Commission of Investigation of Malaria, those gentlemen left this country last week for Sierra Leone.

HULL has lost one of its leading citizens by the death from pneumonia of Mr. Henry Thompson, L.R.C.P.Lond., M.R.C.S. He was highly popular with all classes, held several honorary appointments, and was in possession of an extensive private practice.

DR. LIONEL WEATHERLY, of Bath, has handed the sum of £150 to the Mayor's Transvaal Fund for the sick and wounded as the proceeds of his company of amateurs, who recently gave a performance of "Our Boys" at the Theatre Royal, Bath.

MR. WILLIAM CADGE, F.R.C.S., the well-known surgeon of Norwich, whose death was announced in most of the newspapers as having occurred on December 23rd, has written to the *Times* a letter of thanks for kindly expressed references, which, however, at present are premature. We would echo the wish that their need may long be deferred.

A GENTLEMAN, who for the present wishes to remain anonymous, has generously offered to equip at his own expense a field hospital for South Africa, sufficient to afford accommodation for 100 patients, the hospital staff to consist of four civil surgeons, four nurses, and the usual complement of ambulance men, and other supernumeraries. The offer is greatly appreciated by the authorities, and has been accepted.

FROM South Africa two items of medical interest reach us. Sir William MacCormac has left the camp at the Tugela River and gone to the Western Border to inspect the medical arrangements; whilst Surgeon-Major Burtchall, M.B., B.Ch., who was captured under a flag of truce at the Orange River, has been released by General Cronje.

THE post of Principal Medical Officer to the Local Government Board, which has become vacant by the death of Sir Richard Thorne-Thorne, carries a salary of £1,200 per annum, rising after five years to £1,500. It is expected that Mr. William H. Power, M.R.C.S., who has been for some years assistant Medical Officer to the Board, will receive the appointment.

DR. ED. TAYLOR JONES, D.Sc., has been appointed professor of physics in the University College of North Wales. In 1892 he took the B.Sc. degree with first-class honours at the University of London. With the aid of a Research Scholarship he proceeded to Berlin, where he carried on research work at the Physical Institute, which he embodied in 1895 in a thesis entitled "Electro-Magnetic Stress," and obtained the doctorship of science from the London University as his reward.

THE medical profession is moderately represented in the list of New Year's honours for the last year of the century. Dr. Lauder Brunton, and Surgeon-General F. K. Lovell, of Trinidad, have been created knights. The Hon. J. A. Cockburn, M.D., Agent-General for South Australia, has been created Knight-Commander of the Most Distinguished Order of St. Michael and St. George. Mr. John Pringle, M.B., Member of the Privy Council of Jamaica, has been appointed Commander of the same order, together with Dr. Patrick Manson. A similar distinction has been conferred upon Wordsworth Poole, Esq., M.B., for services rendered as Principal Medical Officer of the West African force on the Niger.

Of the foregoing the name best known in the medical world is undoubtedly that of Thomas Lauder Brunton, whose well-deserved promotion will be hailed with pleasure by a large circle of friends. Dr. Brunton originally took the M.B. of Edinburgh University in 1866, and he now enjoys the almost unique distinction of holding the degrees of LL.D. (Aber.), D.Sc. (Edin.), and M.D. (Edin.). He is the oldest lecturer on *Materia Medica* in London, and for many years acted as Assistant-Physician to St. Bartholomew's Hospital, but has comparatively recently received the post of full physician. He has held various examinerships at the Universities of Edinburgh and London, the Victoria University, and the Royal College of Physicians. He is the author of many well-known books on *materia medica*, therapeutics, and medicine generally. Among other accomplishments Sir Thomas Brunton has a perfect

command of the German language, which serves him in good stead at the International Medical Congresses, where he is a constant attendant. He is to be heartily congratulated in this latest recognition of a life that has been dedicated to sound professional work.

No little surprise has been occasioned in some quarters by the omission of Professor T. R. Fraser's name from the New Year's list. There are two possible explanations for this omission of a name that is in some ways one of the most distinguished in medicine. The first is that it may be forthcoming in a supplementary list. The second that a higher honour than that of knighthood is under contemplation.

THERE are, or will be, several vacancies in the staffs of London general hospitals. Owing to the resignation of Sir Douglas Powell a physician will shortly be required at the Middlesex. Within the next few months, by the retirement rule, both Dr. Sidney Ringer and Mr. Christopher Heath will leave University College Hospital, so that a surgery and a physiciancy will be vacant there. The sudden death of Sir Thorne Thorne will leave a lectureship open at St. Bartholomew's Hospital College.

THE "PURSER" TESTIMONIAL.

THE present and past pupils of Professor Purser, of the University of Dublin, together with a number of the leaders of the profession in Dublin, entertained him on Thursday last at dinner at the Shelbourne Hotel, Dublin, and he was then presented with the first copy of the medal established in his honour by the subscribers for the candidates who score the highest marks in physiology and histology at the University M.B. examination.

The Chair was occupied by J. W. Moore, M.D., President of the Royal College of Physicians in Ireland. After the usual loyal toasts had been proposed and responded to,

Sir CHRISTOPHER NIXON proposed the health of Dr. Purser in a most eloquent speech. Sir Christopher dwelt on the fact that although in the Dublin School clinical teaching had been always of a high order of excellence, yet teaching in its scientific aspects could only be said to date from the appointment of Dr. Purser to the chair of the Institute of Medicine, in the University of Dublin, some 25 years ago. Scientific Physiology and Histology were really first taught in Dublin by Purser. Besides this, for many years he voluntarily gave a course of Practical Pathology to the students, which was characterised by his usual thoroughness, and fully justified the saying that he has devoted his life to his pupils.

The toast was received with great applause.

Professor PURSER in reply said that his heart was full of emotion from the kind way his health had been received, and from the kind things which had been said of him. Still he thought that he would be other than human if he did not feel proud of the honour which had been done him. He felt that it was certainly the highest honour which had ever been paid to him in his life, and must he thought mark the climax of his career. Perhaps it might be thought that some account of his stewardship during this last twenty-five years might be required of him. He thought that physiology was far from occupying that place in the University which it should do, but there appeared to be better times in store for it. He could not enter on the retrospect which might possibly force him to introduce a discordant note which he would like to keep far from this meeting. However, that better things were in store for physiology he felt sure, but he was equally sure that they were not for him. He would be satisfied if he could but see the land of promise from the far side of the valley, and know that the students of the future were enjoying it. He felt that he had failed in many things, but he had always tried to

do his best. He thanked the students, his friends, and all concerned for the very high honour they had paid him.

The President then handed the first copy of the medal which had been founded by his past pupils to Dr. Purser.

The medal, a bronze brass, has a striking portrait of Dr. Purser on one side, and on the other the college arms.

It is to be given annually at the half-yearly M.B. examination in Trinity College to that student who, at the June examination gets highest marks in histology and physiology.

Obituary.

SIR JAMES PAGET, BART.

ON Saturday night, December 30th, Sir James Paget died peacefully in his house at Regent's Park. His end came at the ripe age of 85, and for many years past he had been regarded as the leading figure in the medical world. His honours were many and varied, his intellect and acquirements of a high order, and his interest in religious and philosophical matters no less sincere than profound. On the whole it may be safely said that in Sir James Paget the medical profession has lost one of its most interesting personalities.

The deceased baronet was son of a merchant of Great Yarmouth, where he was born on January 11th, 1814. He received his medical training at St. Bartholomew's School, and took the membership of the Royal College of Surgeons in 1836. Seven years later he was made an honorary Fellow of the same body when that distinction was first created. In 1866 he was elected honorary Fellow of the Irish College of Surgeons, and M.D. of Dublin in 1887. Among other distinctions he was created D.C.L. Oxon.; LL.D. Cambridge; LL.D. Edinburgh; Fellow of the Royal Society; and Fellow of the Royal Society of Edinburgh. After 1884 he was for some time Vice-Chancellor of the University of London. About the year 1860 he was appointed Surgeon to the Prince of Wales, whom he attended in 1872 during the attack of enteric fever that caused great national anxiety at the time. In 1871 he was created a baronet, and six years later the Queen conferred upon him the crowning honour of his professional career by appointing him her serjeant-surgeon. He was President of the Medical Society in 1875 and 1876.

Sir James married a daughter of the Rev. Henry North in 1844. He leaves three sons, Mr. Stephen Paget, who, as a surgeon, inherits much of his father's insight and literary ability; the Rev. Luke Paget, an eloquent and earnest clergyman; and Mr. John Paget, who succeeds to the baronetcy at the age of fifty-one.

Sir James Paget had a wide range of intellectual life, which carried him into many literary and philosophical directions. His power of expression, whether by the pen or in words, was unrivalled for clearness and grace. His eloquence, indeed, was of the first rank, but his speeches, it is interesting to note, were always carefully prepared beforehand and committed to memory. Many of his magazine contributions were perfect specimens of soundly informed and well-reasoned essays in perfect literary form. His best-known contributions to medical literature were "Lectures on Surgical Pathology," and "Clinical Lectures and Casebooks." He also drew up the first of the famous catalogues of St. Bartholomew's Museum.

As a surgeon Sir James was sound, conscientious, and painstaking. He never fully attained, however, the standard of brilliancy in operation that has been associated with most of our brilliant surgeons. At the same time his powers of diagnosis were of a rare and almost intuitive nature. For many years past he had given up all operative work, and since he left the well-known house in Harewood Place some years ago he abandoned altogether the practice of his profession.

The death of this distinguished surgeon, kindly and genial in his private relations, will leave a gap in many circles, professional and social, that will not readily be filled. His connection with St. Bartholomew's Hospital was a

long and close one. He filled the posts of Warden, assistant-surgeon, and surgeon, besides being lecturer upon anatomy, physiology, and surgery at various times. Upon severing his connection with the school in 1873 his portrait was presented to Lady Paget, who gave it to the hospital, where it now hangs.

At the Royal College of Surgeons Sir James served all the offices of importance with the exception, curiously enough, of that of examiner. In 1847 he was Arris and Gale Professor of Human Anatomy and Surgery; in 1865 he was elected a member of the Council; in 1873-4 he served as Vice-President; and in 1875 filled the presidential chair. From 1876-81 he represented the College on the General Medical Council; he delivered the Hunterian Oration in 1877, the first Bradshaw Lecture in 1872, and the first Morton Lecture on Cancer in 1887. He was appointed a trustee of the Hunterian Collection in 1885. A fine bust of this ornament of the medical profession was executed by Boehm in 1886, and stands in the College of Surgeons.

Correspondence

We do not hold ourselves responsible for the opinions of our Correspondents

THE EMPLOYMENT OF EMMENAGOGUES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR

SIR,—As a medical practitioner of some experience I must protest against the tone of your paragraph under the above title in your issue of the 27th instant. Excluding pregnancy, ovarian disease, and mechanical obstructions, there are many cases of functional amenorrhœa that fall within the scope of treatment by drugs. The anæmia or other abnormal blood condition often present is possibly, as pointed out by Dr. Murrell, in your own columns a few weeks since, a symptom rather than a cause, just as in the parallel case of the anæmia that goes with constipation.

If by "emmenagogues" we understand substances that stimulate the non-gravid uterus, and turn to the list of such drugs given in any ordinary materia medica we find myrrh, aloes, ergot, alcohol, cantharis, digitalis, cimecifu, purgatives, hæmatinics, and tonics. As a general rule the administration of any of the foregoing will prove disappointing, and to that extent there may be some small excuse for the editorial attitude of doubt. It does not follow, however, that other drugs are not capable of remedying functional amenorrhœa.

The list given above is taken from a standard work on *Materia Medica* (a), but for all that it is like the play of "Hamlet" without the noble Dane, for it leaves out the most efficient, if not the only efficient remedies of the kind. The active drugs are manganese and senecio. Permanganate of potash, as an emmenagogue, has been before the profession for some fifteen years or more, but there is no doubt that the citrate of manganese introduced by Dr. Murrell is a much more trustworthy preparation. Senecio is the common ragwort; one of the class of composites. It is given in the form of a tincture made with proof spirit in doses of one to two drachms. Dr. Murrell's paper upon the action of those two drugs in functional amenorrhœa, backed as it was with numerous cases, forms one of the most suggestive and valuable contributions ever made to our knowledge upon an obscure yet most important subject. The appearance in the same journal a fortnight later of editorial views apparently of so contradictory and inconsistent a nature, has seemed to the present writer to require some further explanation.—I am Sir,

A BELIEVER IN DR. MURRELL'S EMMENAGOGUES.

Warwick, December 31st, 1899.

[Our paragraph does not traverse Dr. Murrell's conclusions, but was intended to emphasise the worthlessness of emmenagogue remedies—so called—as usually prescribed. We regard the question as still open.—ED. M. P. & C.]

(a) Mitchell Bruce's last edition.

Literature.

ROSE AND CARLESS'S SURGERY. (a)

THE phenomenal event of an annual re-issue of a text-book of surgery in this era of unlimited competition among authors—as well among other candidates for public favour—is in itself a very striking fact in the progress of scientific evolution. The extremely prepossessing volume before us appears to have secured this enviable success. The first edition appeared last year, and judging from the rate at which the present issue is being bought up at the schools of which we have some knowledge, there can be little doubt of its correspondingly rapid exhaustion. The history of this text-book has well justified the ambition of the authors, who state in their modest preface to the first edition that "we have endeavoured to meet what we think is at the present time a genuine need." Highly as we thought of the volume then, we confess that we did not anticipate—in presence of the boundless competition which existed, and the number of failures, and very limited successes in the same department with which our memory supplied us—that it was destined to become, as it has, the guide-book of the present generation of students and practitioners. We are now, of course, wise after the event, and can easily see why it is so. The authors themselves stated that it had been their "aim to present the facts of surgical science in a concise and succinct form, so as to satisfy the needs of the student, even of those who are preparing for the higher examinations. At the same time, the requirements of the general practitioner have not been overlooked. . . ." Such having been the aim of the authors we have only to admire the skill by which the goal has been obtained. We cannot refrain from paying our tribute of respect to the good sense with which "historical and bibliographical references have to a large extent been omitted, whilst diseases of special regions, such as the eye, ear, and female genital organs, are also practically excluded, except in so far as they encroach on the domains of general surgery." The busy, impatient student and the busy anxious practitioner have no time for such information in their every-day *vade-mecum*, and the judicious omission has rendered much valuable space available for a better purpose.

With regard to the special features of the present edition the authors inform us that "The whole of the text has been most carefully and thoroughly revised; many slips, necessarily present in a first edition, have been removed; a considerable amount of new material has been incorporated, so that we trust this edition may be looked upon as fully up to date. Many of the illustrations have been redrawn, others omitted, and new ones have been added." The result now placed before us is a tastefully bound, beautifully printed, and richly illustrated volume of 1,190 octavo pages. The last eighteen of these are occupied by an excellent index—a most important feature in the reference volume of the student and busy practitioner. The illustrations number 400: they are well-chosen, well-executed, and admirably suited for the elucidation of the text in which they are respectively placed; whilst the publisher's department is beyond praise.

Within the circumscribed limits of text books like the volume now under discussion it is, of course, utterly impossible to attempt to deal with varying opinions on the very many topics of surgical uncertainty. The authors have done wisely and well in the interest of their readers in skimming the cream from the still fluid mass of surgical debate and serving it up in the most inviting form for the mental nutrition of their disciples. Every captious critic will, of course, be able to persuade himself that some of the sections with whose subject-matter he happens to be more familiar than with the rest of the volume, might be easily improved by slight

(a) "A Manual of Surgery for Students and Practitioners." By William Rose, M.B., B.S. Lond., F.R.C.S., Professor of Clinical Surgery in King's College, London, and Senior Surgeon to King's College Hospital, &c.; and Albert Carless, M.S. Lond., F.R.C.S., Surgeon to King's College Hospital, and Teacher of Operative Surgery in King's College, London, &c. Second edition. London: Baillière, Tindall, and Cox. 1899. 21s. net.

alterations and additions. But upon the whole the effect upon our own mental vision is almost unqualified admiration. If there is any portion of the work which we would like to receive special attention when preparing the next edition, it would be the part which deals with the very familiar subject of fractures and dislocations. "Dupuytren's fracture" is hardly defined with sufficient clearness, and the figure given does not indicate the displacement which actually occurs. (Pp. 440-441). The paragraph which deals with "Displacement of a Semilunar Cartilage" should—in the light of recent literature—have been more carefully revised. But remarks of this kind are merely a suggested paring of the nails, to show our anxiety to contribute a very little to the almost perfect toilet of an ideal scientific text-book. Accordingly, we will not encourage ourselves to proceed further in this direction. Judging from the conscientious care which the authors have very obviously expended in correcting the small blemishes of the former edition, and making the present issue in every way worthy of the appreciative patronage which its predecessor received, we will anticipate in the coming edition the nearest approach to an ideal handbook for the over-worked student and the busy practitioner, of which our profession has hitherto been able to avail itself. We cannot help contrasting—with some bitter recollections—the volume before us with the corresponding one of our own student days. We heartily congratulate the authors on the well-merited success of their joint labours, and have no hesitation in predicting that with the continued exercise of the same care and judgment they will continue to be the most responsible apostles of surgical doctrine in the opening years of the twentieth century.

HEALTH RESORTS OF EUROPE (a)

THE fact that Dr. Linn's little guide is now in its seventh year of publication, forms ample evidence that it fills a distinct place among the numerous guides purporting to be of service in the selecting of a suitable health resorts.

The book is evidently intended for the ordinary layman as well as for the physician. It is addressed to "invalids going to some European watering-place, or intending to winter in one of the health resorts abroad." Such, however, are warned to "see a medical man before doing so, and not to take counsel of some kind friend who may have been benefited by taking such and such waters, or by living in a certain climate." It is comforting to find that "the family doctor can form a pretty accurate opinion from analysis of waters or meteorological data as to the locality indicated in each case; and no person should come abroad without having competent professional advice, with a written diagnosis or history of his case as well as a probable prognosis."

The "introductory hints and advice" on such points as the time to select for travel, preliminary treatment, clothing, beverages, cost of living, fees, &c., are sensible and suggestive, and will prove useful to inexperienced voyagers.

An alphabetically-arranged list of the various kinds of "cure" is given, and there is also a "Therapeutical Index and Dictionary" from which one can choose a station suitable to the special malady.

The descriptions of the various health resorts and their particular features and beneficial influences are arranged alphabetically under the heads of the different European countries. The actual information respecting the places is, in many cases, somewhat meagre, but the details as to length of journey and travelling expenses from London are given in practically every case, and for this alone the book will prove of the greatest convenience for ready reference.

As far as we have been able to ascertain the information given is fairly accurate. From the invalid's point of view it will form a useful supplement to Bradshaw.

The appendices are somewhat curious. They consist of a list of the officials of the British Balneological and Climatological Society; lists of hydropathic establish-

ments, sanatoria, and private clinics in Austria, France, Germany, Great Britain, Italy, and Switzerland; names of members of the Continental Anglo-American Medical Society and the American Dental Society of Europe; and, lastly, an alphabetically arranged list of the homes in England for the cure of intemperance.

There is an all-too-brief index. Needless to say there are many pages of advertisements, which, it must be admitted, are not without considerable interest to the reader, as well, doubtless, as of some value to advertiser and publisher.

The volume, in spite of its advertisements and business style, cannot but prove of service to the physician, and assistance to the invalid traveller.

Medical News.

The Gresham Lectures.

DR. E. SYMES THOMPSON, Gresham Professor of Medicine, will deliver a course of lectures on "The Perceptions," on January 16th, 17th, 18th, and 19th, 1900, at 6 p.m. each day, at Gresham College, Basinghall Street, London. These lectures are free to the medical profession and to the public generally.

Vital Statistics.

THE deaths registered last week in thirty-six great towns of England and Wales corresponded to an annual rate of 27.5 per 1,000 of their aggregate population, which is estimated at 12,786,832 persons in the middle of this year. The deaths registered in each of the last four weeks in the several towns, alphabetically arranged, corresponded to the following annual rates per 1,000:—

Birkenhead 22, Birmingham 28, Blackburn 19, Bolton 23, Bradford 21, Brighton 35, Bristol 25, Burnley 19, Cardiff 24, Croydon 22, Derby 20, Dublin 42, Edinburgh 19, Glasgow 23, Gateshead 21, Halifax 23, Huddersfield 17, Hull 23, Leeds 18, Leicester 24, Liverpool 33, London 29, Manchester 23, Newcastle-on-Tyne 24, Norwich 22, Nottingham 25, Oldham 21, Plymouth 38, Portsmouth 42, Preston 36, Salford 26, Sheffield 23, Sunderland 29, Swansea 36, West Ham 20, Wolverhampton 35. The highest annual death-rate per 1,000 living, as measured by last week's mortality, were:—From measles, 2.3 in Birkenhead, 2.4 in Hull, and 4.9 in Preston; from whooping cough 1.7 in Leicester, and 1.8 in Liverpool; from "fever" 1.1 in Portsmouth and in Nottingham, and 1.3 in Preston; and from diarrhoea, 1.4 in Burnley. In none of the large towns did the death-rate from scarlet fever reach 1.0 per 1,000. The 128 deaths from diphtheria included 54 in London, 15 in Sheffield, 8 in Leeds, 5 in West Ham, 5 in Portsmouth, 4 in Cardiff, 4 in Manchester, 4 in Birmingham, 4 in Blackburn, and 3 each in Dublin, Brighton, Swansea, Leicester, and Bradford. Eight deaths from small-pox were registered in Hull, but not one in any of the other large towns.

Lifebuoy Soap for the Troops in South Africa.

WE are asked to publish the following item of news:—Messrs. Lever Brothers, Limited, of Port Sunlight, have offered, and the Secretary of State for War has accepted, 5,000 tablets of Lifebuoy Royal Disinfectant Soap for the use of our troops in South Africa. The soap has accordingly been despatched to the Red Cross Commissioner at the front. The hospital and ambulance department of the Canadian contingent was also supplied with Lifebuoy Soap from the Toronto branch of Lever Brothers, Limited. The value of a disinfectant soap of such a recognised reputation and efficacy for use in our field hospitals is self evident, and the gift is sure to be much appreciated.

The Mortality of Foreign Cities.

The following are the latest official returns, and represent the last weekly death-rate per 1,000 of several of the populations:—Calcutta 27, Bombay 58, Madras 43, Paris 20, Brussels 17, Amsterdam 15, Rotterdam 15, The Hague 15, Copenhagen 16, Stockholm 15, Christiania, 15, St. Petersburg 25, Moscow 24, Berlin 16, Hamburg, 16, Dresden —, Breslau 22, Munich 24, Vienna 17, Prague 23, Buda-Pesth 17, Trieste 28, Rome 21, Turin (11 days) 19, Venice 24, Cairo 31, Alexandria 25, New York (including Brooklyn) 16, Philadelphia, 17.

(a) "The Health Resorts of Europe. A Medical Guide to the Mineral Springs, Climatic, Mountain, and Seaside Health Resorts; Milk, Whey, Grape, Earth, Mud Sanit. and Air Cures of Europe." By Thomas Linn, M.D. Pp. 271. London: Henry Kimpton, 1899.

Notices to Correspondents, Short Letters, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

DR. CURTIN.—Yes, we regret to say that the evil reptile that has its being under the name of Christian Science is still to the fore in the United Kingdom. It is nevertheless somewhat surprising that it should have penetrated into so remote a hamlet as that mentioned. An American writer has summed up the tenets of this very peculiar faith in the sentence: "It received its name in 1876, and was a conglomeration of spiritualism, homoeopathy, mesmerism, deceit and avarice." There is much to consider in your contention that a more efficient General Medical Council and an amended Medical Act would soon rid the country of such pests and parasites.

A CLEVER YOUNG DOCTOR!

A CORRESPONDENT sends us the following clipping from the *Christian Budget* for December 29th:—"The very clever young doctor who attended Lady Salisbury, at her special desire, is only twenty-seven years of age, but he has already a very large practice." The world is probably listening with bated breath to hear the name of this "clever young doctor of twenty-seven." Will some reader send enlightenment?

ENQUIRE.—We understand there are over 400 medical men in Toronto, so there can be no great opening there. Our correspondent, however, had better write to someone living on the spot.

THE "MEDICAL DIRECTORY" FOR 1900.

We are asked by Messrs. J. and A. Churchill, publishers of the "Medical Directory," to announce that a disastrous fire at the printers has caused the destruction of the sheets and type. Steps are being taken to replace these, but a delay in sending out the subscribers' copies is inevitable. They hope, however, to publish the volume for 1900 early in February.

DR. DESPREZ.—It has been estimated that the provision of light for school purposes should be equivalent to that admitted by a window 1 yd. square for every 10 sq. yds. of floor, but this of course must be taken in conjunction with the proper distribution of the light.

ARMY MEDICAL DISPENSERS.

In our annotation last week we are made to state that the pay of army dispensers under the new arrangements would be ls. 6d. per day. The amount should have been stated as 5s. 6d. per day.

ERRATUM.—In the review of "Campbell on the Nervous System," in our last impression, please read "Campbell Thomson on the Nervous System."

OUR PARIS CORRESPONDENCE.—Owing to the irregular nature of the Channel service, occasioned by the stormy weather our weekly budget from Paris only arrived as we were "at press," too late for present issue.

DR. E.—De Sanctis states that the result of a large number of observations has been to show that dreams are more frequent in women than in men. Out of 160 men 50 dreamed rarely, 27 often, and 13 constantly; of 100 women 50 dreamed constantly, 45 often, and 13 rarely. Commenting on the expression to "sleep the sleep of the just," he remarks that the greater the criminal the better he sleeps, in fact, the ability to sleep is in inverse proportion to "cerebrality," and from this point of view professional criminals are low down in the scale.

Meetings of the Societies and Lectures.

WEDNESDAY, JANUARY 3RD.

OBSTETRICAL SOCIETY OF LONDON.—8 p.m. Specimens will be shown by Drs. Eden, Macnaughton-Jones, John Phillips, and others. Paper—Dr. Herbert Spencer: Four Cases of Rupture of the Uterus successfully treated by Packing the Tear per Vaginum with Iodoform Gauze.

THURSDAY, JANUARY 4TH.

HARVEIAN SOCIETY OF LONDON.—8.30 p.m. Clinical evening. **HÖNTEGEN SOCIETY** (20, Hanover Square, W.)—9 p.m. Mr. Chisholm Williams: The Interpretation of Skiagraphs.

FRIDAY, JANUARY 5TH.

LARYNGOLOGICAL SOCIETY OF LONDON (20, Hanover Square, W.).—4.30 p.m. Annual general meeting. Lantern demonstrations of Normal and Pathological Preparations of the Nose and Throat will be given by Dr. Watson Williams and Dr. Jobson Horne. Cases will be shown by Sir Felix Semon, Mr. Waller Spencer, Dr. Fitzgerald Powell, Dr. Herbert Tilley, Mr. L. A. Laurence, Mr. Stephen Paget, Mr. Lake, and others.

MONDAY, JANUARY 8TH.

ODONTOLOGICAL SOCIETY OF GREAT BRITAIN.—Special meeting for the purpose of considering the following proposed new bye-law, which has been recommended by the Council:—"That the Council be empowered to make Grants in aid of Scientific Research in connection with Dentistry." After disposal of the above, the meeting will be made ordinary for the adjourned discussion of Mr. J. F. Colyer's Paper on "Some Notes on the Treatment of Superior Protrusion."

Appointments.

FAGAN, A. St. L., L.R.C.P.Lond., M.B.C.S., Medical Officer for the Upper Holloway Central District, London.
FLEMING, G., M.B., C.M., M.B.C.P.E., Medical Officer for the Omberley District of the Droitwich Union.
GOUGH, J. Harley, F.R.C.S.Ed., L.R.C.P.Lond., Honorary Physician to the Western Hospital for Consumption, Torquay.
HILL, A. A., L.R.C.P., L.R.C.S.Ed., L.F.P.S.G., Certifying Surgeon under the Factory Acts for the Urban District of Tunstall.
LYDD, E. E., L.R.C.P.Lond., M.B.C.S., Assistant Medical Officer for the Infirmary of the Parish of Fulham.
ROSE, GEORGE, M.B., C.M., D.F.H.Aberd., Surgeon to the Royal Aberdeen Hospital for Sick Children.
ROWLANDS, W. H., L.R.C.P.Lond., M.B.C.S., Medical Officer of the Workhouse, Bromsgrove Union.
STURROCK, A. Corsar, M.A., M.D. Ed., Resident Medical Officer to the Royal Infirmary, Manchester.
THOMPSON, WALTER, F.R.C.S.Eng., L.R.C.P.Lond., Honorary Surgeon to the Hospital for Women and Children, Leeds.
WOOD, E. STANLEY, L.R.C.P., M.B.C.S., Medical Attendant at the Borough Infectious Diseases Hospital at Cambridge.

Vacancies.

Central London Ophthalmic Hospital, Gray's Inn Road,—House Surgeon. Salary at the rate of £50 per annum, with board and residence in the Hospital.
City of London Hospital for Diseases of the Chest, Victoria Park, E.—Second House Physician for six months. Salary at the rate of £30 per annum, with board and residence.
City of York.—Medical Officer of Health. Salary £400 per annum. Apply to the Town Clerk, Guildhall, York.
County of Sutherland.—Medical Officer of Health for the County of Sutherland. Salary £300 per annum, and £50 in lieu of travelling and other expenses, with certain exceptions. Applications to the County Clerk, Golspie.
Leicester Infirmary.—House Physician for 12 months. Salary £100 per annum with board, apartments, and washing.
Middlesex Hospital, W.—Assistant in the Cancer Research Laboratories. Salary £100 per annum, with an honorarium of £50, after second year of office.
National Hospital for the Paralyzed and Epileptic, Queen Square, Bloomsbury, London.—House Physician. Salary £100, with board and apartments.
Parish of St. Mary, Islington.—Medical Superintendent for the new Infirmary at Highgate Hill. Salary £500 per annum, with unfurnished residence, coals, gas, and washing. Applications to the Clerk to the Guardians, St. John's Road, Holloway, N.
St. Mary's Children's Hospital, Plaistow, E.—Senior Resident Medical Officer for one year. Salary £90 per annum, with residence in the hospital, board, and washing.
St. Marylebone General Dispensary, London, W.—Resident Medical Officer. Salary commencing at 100 guineas per annum, with furnished apartments, attendance, coals, &c.
Three Counties Asylum, near Hitchin.—Second Assistant Medical Officer. Salary £150 per annum, with board, apartments, washing, &c. Apply to the Clerk, St. Neots, Hunts.

Births.

BOKENHAM.—On December 25th, at Devonshire Street, Portland Place, London, W., the wife of Thomas J. Bokenham, M.B.C.S., of a daughter.
BROWN.—On December 27th, at 6, Gibson Square, London, N., the wife of George Brown, M.B.C.S.Eng., of a son.
HOLT.—On December 27th, at 18, Anglesey Crescent, Alverston, Hants, the wife of Surgeon-Captain Holt, R.A.M.C., of a son.
RUTHERFORD.—On December 30th, at 12, Newton Place, Glasgow, the wife of Henry Rutherford, M.B., of a daughter.
WHITE.—On December 30th, at 100, Lewisham Road, Lewisham, S.E., the wife of Malcolm White, M.B.C.S., L.R.C.P., of a son.

Marriages.

KYLE—WIGHT.—On December 29th, at the Anglican Church of St. John the Baptist, Buenos Aires, Juan Macdonald Kyle, M.D., of Conchillas, Uruguay, eldest son of Dr. J. J. Kyle, of Buenos Aires, to Margaret, youngest daughter of Henry P. Wight, of Bournemouth, formerly of Newcastle-on-Tyne. (By cable.)

Deaths.

CURTIS.—On December 29th, at Thanet House, Staines, Albert Curtis, M.B.C.S., L.S.A., second son of the late Frederick Curtis, in his 65th year.
LOCKETT.—On December 30th, of pneumonia, at 76, Herbert Road, Woolwich, John A. Pope, M.B.C.S., L.R.C.P., aged 38.
MEADE.—On December 24th, at Mount Royal, Bradford, Yorks., Richard Henry Meade, F.R.C.S., J.P., aged 85 years.
Ogilvy.—On December 23rd, suddenly, at Frimley Lodge, Frimley, Surrey, Surgeon-General John Ogilvy.
ORR.—On December 29th, at Wollaston, Wellingborough, James Wm. Orr, M.B.C.S., L.R.C.P.
PAGET.—On December 30th, after a few days' illness, Sir James Paget, F.R.C.S.Eng. and I, M.D.Dub., D.C.L.Oxon, LL.D. Cantab., F.R.S., Surg.-Surgeon to H.M. the Queen, Surgeon to H.R.H. the Prince of Wales, aged 85.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXX.

WEDNESDAY, JANUARY 10, 1900.

No. 2.

The Harben Lectures.

DIPHTHERIA

By PROFESSOR WILLIAM R SMITH, M.D., D Sc.,

F.R.S.Ed., BARRISTER AT-LAW,

President of the Royal Institute of Public Health, Harben
Lecturer for 1899.

ABSTRACT OF LECTURE I.

In the course of the three lectures which it is my privilege this year to give under the terms of the Harben Trust of our Royal Institute, I shall endeavour to deal as exhaustively as I can with that most interesting disease diphtheria—interesting to us from whichever point of view its study be approached, whether from the standpoint of its spread, its etiology, its treatment, or its prevention. And in thus dealing with the subject I shall have occasion to draw largely upon the experience I have obtained first as Medical Officer to the School Board for London, and secondly as chairman of the Medical Sub-Committee of the Metropolitan Asylums Board, to which sub-committee was entrusted the superintendence of the bacteriological examination of the diphtheria cases admitted into the hospitals of the Board over a prolonged period, and also the arrangements in connection with the preparation and supply of the antitoxic serum for the treatment of diphtheria cases.

From a study of the history of this disease there would appear to be no doubt that the disease has been known for many centuries, and, further, that one decided remission occurred (at the close of the eighteenth century) which was, however, followed by a sudden outbreak over a very greatly extended area.

In England the Registrar-General has only separately abstracted diphtheria deaths since the year 1855; up to that time such deaths as occurred were classified under the head of scarlet fever.

On examining the death-rates per million from diphtheria in England and Wales since 1855, and in London since 1859, we find that the deaths rose gradually during the years 1855, 1856, 1857, and then with a bound in the years 1858 and 1859; but during these latter years it should be noted that scarlet fever also was prevalent, and there may have been some inaccuracies in diagnosis. In 1860 the mortality fell nearly one-half, and after a recrudescence between 1861 and 1864 it fell almost continuously until it reached a minimum in 1872. There was a slight rise in 1874 to 1876, after which the rate again became very low both for all England and for London. From 1878, however, there was a steadily increasing prevalence, slow at first, but afterwards more rapid, especially in London. In 1893 the all-England rate reached 318 per million, which is the highest since 1859, and the London rate was as high as 761 per million, or more than double the rate in London in any previous year except 1892. Since 1893 the rates have shown a tendency to decrease; this has been most marked in London, and may be partially if

not wholly accounted for by improved methods of treatment

The diphtheria death-rates in England and Wales, and in London, in various periods up to 1897, for each of the first five years of age, and for groups of ages afterwards, show an enormous increase in the mortality for ages up to five, that in the London area during the periods 1881-90 and 1891-98 being most noticeable.

Diphtheria is more prevalent in temperate and cold regions than in the tropics, and in London both the mortality and the prevalence are greatest during the quarter ending December and lowest in the quarter ending June. Hirsch has shown that the same seasonal relationship exists in Sweden, Berlin, St. Petersburg, Vienna, and Philadelphia.

I now propose, in the first place, to draw particular attention to the evidence which can be obtained from statistics bearing upon the mortality from diphtheria in the past, so far as such statistics affect the country at large; I shall then deal more particularly with the statistical evidence available for London; and thirdly with that of other large European and American cities.

In the early history of the disease there is a distinctly marked tendency for the higher mortality rate to prevail in the less densely-populated districts; this Dr. Longstaff showed in a report published in 1887. The report reveals also an important change in the incidence of the disease, as judged by its mortality, in the latter periods for which the observations were made.

Death-rates from diphtheria according to density of population:—

Period.		Sparse.		Medium.		Dense.
1855-60	...	248	...	182	...	123
1861-70	...	223	...	164	...	163
1871-80	...	132	...	125	...	114

Dr. Longstaff obtained this table by grouping the registration districts of England and Wales under the headings of sparsely, medium, and densely populated, according to the relationship of the acreage to the number of the inhabitants, and it will be seen that, whereas in 1855-60 the rate in the sparsely-populated areas was more than double that in the dense districts, the rate in the decennial period 1871-80 had markedly fallen in sparsely populated localities, whilst it was almost at the same level as in the period 1855-60 in the more crowded parts of the country.

From a communication which I have received from Dr. Longstaff in this connection, I find that sometime ago he commenced to analyse the returns for the ten years 1881-90, with the result that he found considerable changes in the geographical distribution of the disease, but that so far as he went the figures did not seem to point to any very definite conclusions. He also informs me that the researches of Dr. Eig nbrodt, of Darmstadt, confirmed his principal result—viz., that diphtheria in its first incidence chiefly attacks rural districts—which he explains conjecturally as the consequence of hereditary pre-

disposition to throat disease intensified by breeding-in.

Not only, however, has the disease during the period for which observations have been recorded varied in its incidence on locality according to the density of population, but it has also varied in its incidence in England and Wales as a whole.

Looking at the figures for the whole country, we find that a sharp fall in the rate occurred in the decade 1871-80 as compared with the preceding period; in 1881-90 a rise occurred, but not sufficient to bring the rate to its level in 1861-70; but in 1891-98 a further rise took place, bringing the mean rate for the eight years to a higher figure than had been reached in any previous single year since 1864. The mean rate in 1860-64 was, however, slightly higher than that in the last eight years, and the rates in the two years 1858 and 1859 were higher than the rate in any one of the years 1891 to 1898. For the whole country, then, the diphtheria mortality in recent years has been high, but not so high as it was a generation earlier.

Turning, however, to the separate counties, remarkable variations are at once apparent. It is true that the decrease of mortality in 1871-80 was, with a few insignificant exceptions, shared by the whole country. But not so the increase of mortality of the periods 1881-90 and 1891-98, which was very considerably greater in the southern than in the northern parts of the country. This will be well seen if a line be drawn across the map of England, starting from Yarmouth, passing north and west of Suffolk, then south of Cambridgeshire, Hunts, Northamptonshire, Warwickshire, and Worcestershire east and north of Herefordshire, and along the line separating South from North Wales. In every one of the twenty-two counties to the south of this line the diphtheria rate was higher, either in 1881-90 or in 1891-98, than it had been in 1861-70; on the other hand, only five of the twenty-three counties to the north of the line—viz., Leicester, Staffordshire, Worcestershire, Lancashire, and Durham—had higher rates, either in 1881-90 or in 1891-98, than they had had in 1861-60.

A convenient method of showing the *distribution* of diphtheria through the country independently of its special severity at any time is to represent the rates of mortality in the various counties by the proportions they bear to the rate in the whole country at the same period. One of the most significant of the facts thus made prominent, is that certain counties have, in each of the four periods, had diphtheria death-rates exceeding that for the whole country. These counties are Surrey, Kent, Sussex, and Essex. The rate for London and for one other county (Middlesex) was less than that for the whole country in 1861-70, but greater in each of the other periods; and the rates for Shropshire and North Wales were greater than the rate for the whole country in the first three periods, but less in 1891-98.

If, with the aid of coloured and shaded maps, we attempt to trace the spread of diphtheria in the south-eastern corner of England, we find that in 1861-70 London—with a rate slightly less than that of the entire country—was partly surrounded on the east and south by counties whose diphtheria mortality was relatively high. In 1871-80 the mortality in London still remained practically equal to that of England and Wales (which had fallen by one-third), but the ring of relatively diphtheritic counties had become complete around it, and in the two following periods the mortality in London itself increased enormously. Another point which is clearly brought out is that although the death-rates from diphtheria in several of the northern counties exceeded the rate in the whole country in 1861-70 and 1871-80, the excessive mortality has, during the last eight

years, been confined to the south-eastern part of the country and to Monmouthshire and South Wales.

A general statement that the *southern counties* of England have suffered their highest diphtheria rates since 1881, and that the *midland and northern counties* (excepting Leicester, Lancashire, and Durham) had suffered theirs before 1871, is very near the truth; and it must be noted that this southern area includes not only London and the immediately surrounding counties, but a number of agricultural counties, which cannot by any stretch of the imagination be supposed to be constantly infected from London; and, on the other hand, the northern area of low diphtheritic rates since 1871 comprises thickly-populated towns and congeries of towns, in which all the influences of mere aggregation in the spread of the disease are likely to be more active than in London, and *far more active* than in such agricultural districts as Bucks, Oxfordshire, and Suffolk, counties whose recent diphtheria rates exceed those shown in any of the four periods in Lancashire.

Speaking generally we find that the mortality from measles, like that from diphtheria, declined in the decade 1871-80, and rose in 1881-90. Only four counties (Devonshire, Monmouthshire, and North and South Wales) showed *greater* mortality in 1871-80 than in the previous decade; and only seven (Devonshire, Monmouthshire, North Wales, Shropshire, Leicestershire, Lincolnshire, and Westmoreland) showed less mortality in 1881-90 than in 1871-80.

When, however, we inquire more closely into the matter we find a remarkable difference of behaviour between diphtheria and measles. The mortality in certain counties was greater than in the country as a whole during each of the four periods. These counties were London, Monmouthshire, Staffordshire, Lancashire, and Durham. The relative freedom of the southern counties from measles is as remarkable as the liability of several of them to diphtheria. The measles rate in Northamptonshire and in Cornwall exceeded the rate in England and Wales during 1861-70, and the rate in Devonshire was excessive in 1871-80, but these are the only cases in which the rate in any southern county except London has exceeded the rate for the whole country in *any one* of the four periods.

Applying the same line of reasoning to cases of scarlet fever, we find that the changes in scarlet fever mortality have been altogether of another kind, indeed the tendency throughout the country has been towards a rapid and continuous decline. In the country as a whole, the mortality in 1891-98 was only a little more than one-sixth of what it had been in 1861-70, and every single county shows a much lower rate in 1891-98 than in 1861-70. Indeed, only three counties fail to show a *successive* decline of mortality in the four periods covered by the table. Of these exceptions, the increase in the scarlet fever mortality of Middlesex in 1891-98 is probably accounted for by the establishment of the Metropolitan Asylum Board's Northern and North-Eastern Hospitals in Tottenham, while the others are too small to be of real importance.

Statistics show that the mortality in Staffordshire, Lancashire, the West Riding, Durham, and South Wales was in excess in each period, and in Cheshire, Northumberland, and Monmouthshire in three periods out of the four. It will be noted that Staffordshire, Lancashire, Durham, and Monmouthshire, occupy a similar unhappy pre-eminence in regard to measles also: while, on the other hand, Staffordshire, Lancashire, the West Riding, and Durham are among the counties whose diphtheria rates have in each period been below those of the whole country. The similarity of the local distributions of measles and scarlet fever, and their contrast with the loca

distribution of diphtheria, will be still more clearly seen by mapping them out, and by comparing the maps relating to diphtheria and measles with that of diphtheria.

The general result of such an examination appears to be that, although the spread of every infectious disease must necessarily be favoured by bringing together large numbers of those most liable to it, yet the conditions most favourable to the diffusion of measles and scarlet fever are not those most favourable to the diffusion of diphtheria. In other words, if we wish to explain why Sussex is comparatively free from measles (one of the most infectious, if not the most infectious, disease among children) and scarlet fever, but suffers from excessive diphtheria mortality, while Staffordshire is comparatively free from diphtheria but suffers excessively from measles and scarlet fever, we must look for some conditions which are not common to the two counties.

It may be suggested that such a condition is found in the fact that Sussex is much nearer to London than is Staffordshire; but this suggestion fails entirely to meet the case, since the special liability of Sussex to diphtheria began several years before that of London; and, moreover, Staffordshire shares the liability of London to excessive measles mortality, while Sussex does not. Again, if school infection is the chief cause of the mortality from diphtheria in Sussex, why should Staffordshire escape? And if school infection is the chief factor in the spread of measles and scarlet fever in Staffordshire, why should Sussex escape? It is evident that several agencies must be at work in spreading zymotic diseases among children, and it may be taken as highly probable that the vicinity of infected centres is one, and school infection is another of those agencies. But the comparison of the geographical distributions of three of these diseases strongly suggests that special local causes other than school attendance, or the neighbourhood of infected centres, have a potent influence in selecting the disease and promoting its diffusion.

Dr. Arthur Newsholme, in his book on epidemic diphtheria, demonstrates two facts very clearly: first, that London compares very favourably with the majority of these towns in regard to its diphtheria death-rate; and, secondly, that all towns, whether endemic centres of this disease or not, are liable at varying intervals to epidemic outbursts of a severe character, lasting over a period of several years. The value of the statistics thus brought forward is somewhat diminished from the fact that the only evidence attainable of the prevalence of the disease from year to year is from the number of deaths per 100,000 of the population, although the case mortality must have been subject to considerable variations, and is therefore not a true measure of incidence. As the author points out, however, notification has been in force for too short a period to afford trustworthy evidence of the prevalence of the disease over any considerable period of time. Again, it has been necessary in some cases to group together the mortality from diphtheria and croup, that from diphtheria alone not being forthcoming. In many cases, however, the death-rates from diphtheria alone are also available.

This author shows that:—

	Mean death-rate for	per 100,000,
New York ...	27 years of	109
Berlin ...	27 "	101
Boston ...	34 "	100
Christiania ...	33 "	80
Chicago ...	35 "	77

While the greatest mortality for any year in London was 76, this occurring in 1893. With regard

to the maximum annual diphtheria mortality in these towns, the figures are still more striking:

In 1887 the death rate of Christiania was 303 per 100 000; in 1883 the death-rate of Berlin was 220 per 100,000; in 1877 the death-rate of New York was 208 per 100,000.

While Boston and Chicago in America, Frankfort-on-Maine in Germany, Buda-Pesth and Vienna in Austria-Hungary, St. Petersburg and Moscow in Russia, Gothenburg and Stockholm in Scandinavia, all furnish death rates of considerably over 100 per 100,000. The highest corresponding figure for London, as previously stated, being 76.

When the combined death-rates from diphtheria and croup are examined, similar results are obtained, and the list of excessive mortalities is swelled by the returns from Buenos Ayres, Paris and Marseilles, Milan, Florence and Rome, Brussels and Antwerp, Dresden and Munich, and Trieste, in addition to those towns already mentioned.

In the case of Florence, the maximum mortality from these two diseases reached 422 per 100,000 in the year 1871, while the death-rate in New York, Chicago and Buenos Ayres, Milan, Dresden, Trieste, Christiania, and Gothenburg was above 250.

With regard to the maximum epidemic years of the different towns, Dr. Newsholme's figures show that not only were epidemics prevalent during different years in the different countries, but they occurred in different years in the various towns of the same countries; and in the case of Brussels there was a difference in this respect even between the city and its suburbs, for in the course of an epidemic which reached its height in 1862, the decline was some years later in the suburbs than in the city itself, and in fact, was scarcely over when a second epidemic over-ran the whole district, culminating in the year 1885.

Taking these figures into consideration, it is evident that, so far from there being at the present moment a formidable death-rate from diphtheria in London, this city has been spared in a remarkable manner from the lot which has fallen to most American and European cities of importance. Moreover, it seems possible that the present increase in the diphtheria death-rate may be accounted for by the occurrence of a period of epidemicity of the disease, mild at present as compared with that which has been experienced by the towns of other countries in previous years, this epidemicity being due to general causes, of which we have at present no knowledge, and which we therefore cannot hope to control until that knowledge is obtained.

Now what is the nature of this disease we call diphtheria? We recognise it to be a disease of a specifically infectious character, primarily affecting mucous membranes, and most commonly the upper portions of the respiratory and digestive tracts. At first it is a purely local inflammation, characterised by the formation of a false membranous deposit, the system only secondarily becoming affected. The disease is occasioned, as we now all know, by the reception at a particular point of the affected surface of the Klebs-Löffler *bacillus diphtherie*, which micro-organism must be considered as the specific and essential cause of the local complaint, whilst the general system is subsequently implicated owing to the absorption of the chemical poison or toxin, which is formed during the growth of the organism in the throat.

This organism is always found in connection with the false membranes associated with diphtheria, and for this reason, therefore, it becomes a question of prime importance that bacteriological tests should be applied in all cases of suspected diphtheria. The bacillus is extremely polymorphic, but two varieties may be noted—the long and the short.

Usually no difficulty occurs in recognising the diphtheria bacilli either upon the surface of the nutrient media or under the microscope, but occasionally a difficulty arises, for organisms closely resembling Klebs-Löffler bacilli are found in healthy and non-diphtheritic sore throats, which have been described as pseudo-diphtheria bacilli. Some observers give this name to organisms bearing a superficial resemblance to the true diphtheria organism, whilst others apply the term to organisms which morphologically cannot be distinguished from the typical bacillus, but which differ from it in so far as they fail to produce any pathogenic properties when injected into guinea pigs. The exact connection of these organisms with the true bacillus is not clearly understood.

The evidence justifying the assertion that the Klebs-Löffler bacillus is alone the cause of diphtheria is of a very interesting nature. True diphtheria apparently never arises spontaneously in the lower animals, with the single exception of the cat. In this animal, Dr. Klein, to whom we are much indebted for many able researches on the subject, has described a disease characterised by broncho-pneumonia, cardiac disease and ophthalmia, whilst in the consolidated portions of the lung he has found the diphtheria organism in considerable numbers. He consequently concludes that cats are susceptible to human diphtheria, and that in them the disease principally affects the lungs. He has also shown that inoculation of the conjunctiva or of the mucous membrane of the mouth of the cat with diphtheritic material is followed by changes closely resembling the disease in the human subject.

Our bacteriological knowledge of the disease has been greatly advanced by the enlightened policy of the Metropolitan Asylums Board, of whose work in connection with the treatment of infectious disease in London it is impossible to speak too highly. Consequently upon representations made to the Board, in which this Institute played no insignificant part, it was determined that not only should bacteriological tests be instituted in all cases of suspected diphtheria, but that so far as possible these tests should—at least, in the first instance—be made upon a uniform basis, the responsibility being centred in one person.

During the three years covered by the statistics kindly placed at my disposal, out of 12,173 cases, diphtheria bacilli were found at the last examination in no fewer than 4,052, or 33.28 per cent.; and if we note the figures for the different years, we find that:

In 1894 there were 25 such cases out of 45, or 55.5 per cent.

In 1895—1,594 such cases out of 5,296, or 30.1 per cent.

And in 1896—2,433 such cases out of 6,832, or 35.6 per cent., with the specific organism still in the throat at the last examination, and although it would be unfair to assume that all these cases had bacilli in their throats when discharged from hospital, yet doubtless in a fair proportion of the cases there can be no question that the organism was present, ready to be transmitted to those to whom the patient might come in contact. Bearing in mind the prevalence of diphtheria in London, and the fact that diphtheria can readily be transmitted by patients apparently well, this point would appear to have great importance from the danger to which such cases may expose the public. There, is, however, another practical point to be observed. It will be noted that there were a certain number of cases in which bacilli were not found at the first examination, but were demonstrated subsequently. From this it must be concluded that the diphtheria bacillus, though present, was overlooked. Occasionally infection may have taken place after the first examination, and a subsequent examination confirmed the

diagnosis, but the importance of making more than one examination is demonstrated in all cases where a doubt exists, especially in those where a negative bacteriological diagnosis is given.

There exist differences of opinion as to the influence on the course of the disease of different forms of diphtheria bacilli when present alone or in combination with streptococci and staphylococci. As regards the diphtheria bacillus alone, the highest mortality appears to be associated with the long bacillus, and in cases of mixed infection the most fatal form occurs when the bacillus is associated with the streptococcus group. The short bacillus would appear usually to have such slight virulence that it merely gives rise to a mild attack of sore-throat, but we must be careful to guard ourselves against the assumption that such cases do not contain specific infection, or that the throats in which they are found are not sources of infection; but in 148 cases in which the short bacillus was alone found there were only five deaths. In all cases it appears that mixed infections give rise to graver lesions than simple infections, even with the most virulent form of diphtheria bacilli.

In respect of the cases for 1895 and 1896 in which no diphtheria bacilli were found after repeated examinations it is worthy of note that in 3,236 cases, or 26.5 per cent. of the total cases examined during the two years 1895-96, no diphtheria bacilli were found, so that even allowing for errors of observation, over 20 per cent., or some 3,000 cases, were admitted to the Asylums Board's hospitals which offered no evidence, clinical or bacteriological, of diphtherial infection. The importance of these observations cannot be overstated, if only from the point of view of beds being occupied which could more properly be filled by genuine cases of diphtheria.

In that most fatal form of diphtheria, viz., hæmorrhagic diphtheria, the long and irregular forms of diphtheria bacilli were demonstrated in the throats of the patients, and in a large proportion of the cases there were staphylococci present either alone or in combination with the streptococci.

As a result of the observations made, the persistence of the diphtheria bacillus for periods up to eight weeks was of common occurrence, whether treatment by antitoxin was adopted or not, whilst the majority of cases seem to retain bacilli in the throat from two to nine weeks. After the ninth week the number appears to fall very rapidly. In the year 1895 two cases were found to have the infective bacillus present beyond 200 days—in one of these antitoxic serum was used; and a considerable number remained infective beyond 100 days.

In 1896 no cases were found in which diphtheria bacilli were present after the 189th day among the injected cases, and after the 169th day among the non-injected cases. Ninety-four still contained bacilli on the mucous membranes after the 100th day among the injected cases,

OTORRHOEA AND ITS TREATMENT.

By DR. PAUL RAUGE.

(Concluded from page 7.)

Treatment of Suppurative Otitis before Perforation of the Tympanic Membrane.—In spite of these precautions, supposing they have not been neglected, the microbes may pass through the Eustachian tube, determining infection and suppuration of the tympanum. As long, however, as the tympanic membrane is intact, the suppuration is going on in a tightly corked bottle, so to speak, the microbe to which the condition is due forming cultures in a state of purity, without any secondary

infection. This is the monobacillary stage, with which a suppurative otitis invariably begins. The question then presents itself, whether it is better to follow the old rule of evacuating pus wherever found, or, on the contrary, preserve the protective membrane which wards off the danger from outside. If this protection could be kept up indefinitely, and the contents of the tympanum were likely to be absorbed, there would be no doubt of the best course to be adopted. As a rule, however, an abscess which one hesitates to open to-day will open of its own accord to-morrow, and, such being the case, it is certainly preferable to have recourse to surgical means for evacuating the pus under the best possible conditions, rather than to run the risk of a spontaneous evacuation, which can neither be directed nor controlled.

There is perhaps no surgical operation which a medical man is so unwilling to perform as paracentesis of the tympanic membrane; yet, it is one of those which should be done most frequently, in the first place because it is an extremely easy one and absolutely harmless, and secondly because there are few operations which exert so marvellous an influence on the existing symptoms and threatening dangers. This operation, which after all is nothing more than a puncture with a needle, instantly alleviates the excruciating pain, saves the hearing of the patient, and prevents complications which may seriously threaten his life.

There is therefore no need for me to dwell upon the indications of paracentesis, for in my opinion there is but one, viz., the presence of pus in the tympanum. If the tympanic membrane is tense and yellowish, if it bulges toward the auditory meatus, and if severe pain exists, there is only one thing to be done, and that is to open the abscess without delay. The cavity of the tympanum being as yet but slightly infected, this simple incision should be performed under as rigorously antiseptic conditions, as if it were a question of entering the peritoneum or the pleura. The auditory canal should be carefully washed, first with soap, then with alcohol, and lastly sprinkled with a 1 : 1,000 mercury perchloride solution. The speculum and the needle should be sterilised either in an antiseptic bath or, better still, in the stove or by flaming. The needle used for the paracentesis consists of a simple steel rod, more or less inclined with reference to the handle, with an enlargement at the tip in the form of a lancet. The cutting edge of this tip should be subjected to a preliminary examination, either by a magnifying glass, or by trying it on a tightly stretched piece of an old kid glove, as is done with cataract knives, for on the condition of this edge depends the success of the perforation, and more particularly the degree of pain it causes. Moreover, although it is generally admitted that cocaine has no effect on the tympanic membrane lined with its epidermis, it is always well to instil, before the operation, a few drops of a strong solution (10 or 20 per cent.) of this anæsthetic.

With regard to the operative technique, it is sufficient to remember that the incision should always be made in the infra-umbilical region, where there is no important organ to look out for. The umbilicus corresponds exactly to the promontory, and as the width of the tympanum at this spot is only from $1\frac{1}{2}$ millimetres to 2 millimetres, the puncture should always be made lower down, near the floor, where the distance between the membrane and the inner wall of the tympanum is at least 4 millimetres. It is a matter of indifference whether the puncture be made in the anterior or posterior region of the lower half, whether the incision be horizontal or vertical, although the latter is somewhat better adapted to facilitate escape of the pus, and conforms better to surgical rules. The ear being well lighted and the head of the patient being held firmly by an assistant, the operator selects the spot for the incision, and with a sudden, determined movement the point of the needle is pushed in to the depth of 2 or 3 millimetres, and then withdrawn in a slightly inclined direction, in order to effect an enlargement of the opening as it is pulled out. Evacuation of the fluid is facilitated either by Politzer's douche, or by aspiration through the auditory meatus either with Siegle's pneumatic speculum or Delstanche's rarefactor. The dressing consists simply

in the introduction of a cotton pad, soaked in carbolic acid dissolved in water or glycerin, or preferably a strip of sterilised or iodoform gauze, which is frequently changed, in order to prevent stagnation of the fluids. Care being taken to thoroughly dry the auditory canal each time.

Treatment of Simple Otorrhœa.—After paracentesis of the membrana tympani, three conditions may present themselves; the surgical traumatism and the lesions which have necessitated it may heal immediately and completely; or the incision heals, but the abscess is reproduced, and the operation must be repeated, possibly several times, as long as the tympanic cavity still contains pus; lastly, the wound may remain open, the discharge persisting. Whether the fistula follows an incision or, as is more frequently the case, spontaneous perforation of the membrane, it shows that the affection is becoming chronic, and that the discouraging stage is entered upon, of which it is impossible to foresee the termination, no relief being obtainable except at the cost of a serious operation.

The treatment of otorrhœa is not only one of the most difficult tasks which may fall to the lot of the medical man, but also a source of continual anxiety. It is certainly humiliating to see a discharge from the ear continue for months in spite of all that may be done to stop it, and it is terrible when one knows that, as long as this suppuration persists, there is danger of its leading to complications with a fatal issue. Not that there are no means of combating the affection itself. On the contrary, they are too numerous, and we have only to choose between them, but the difficulty of the matter lies in being able to recognise when the moment comes for giving up dressings and irrigations, and having recourse to the knife and the curette. However much the various measures for treating otorrhœa may differ in detail, there are in reality only two distinct methods, diametrically opposed to each other, of dealing with this affection.

One is based on expectation, leaving the organism to drive back the pyogenic germs, eliminate the necrosed parts, and repair the loss of tissue, while medication is simply limited to sanitation of the battlefield, so to speak, carrying away the dead, sweeping out the morbid secretions, and barring the access to the diseased cavities by suitable dressings. This is the method of antiseptic defence.

The other is the method of active attack, in which the medical man does not content himself with merely insuring evacuation of the pus, doing away with its irritating effect, and preventing septic transformation, but endeavours also to destroy its source by chemical action on the mucous membranes which furnish it, or by removing by the aid of surgical operations the sequestra and necrosed tissues, which, here and elsewhere, by efforts at spontaneous elimination keep up the inflammatory reaction and persistent suppuration.

A beginning is invariably made by the application of an antiseptic treatment, which may be abandoned at any time sooner or later, according to the persistency of the lesions, the character of the symptoms, and the impatience of the patient. There are, in fact, only two things to do, to destroy the culture medium by removing from the affected cavities the fluid as it is formed, and to forestall complications by preventing the micro-organisms of secondary infection from gaining access to the tympanum. The treatment in this case is therefore reduced to cleansing of the ear and the application of a suitable dressing.

In spite of the severe criticism that has been made of irrigation of the auditory meatus, it remains the simplest and most generally employed method of cleansing the ear. Non-aseptic irrigations, which affect the tympanum, instead of cleansing it, are of course to be condemned under any and all circumstances; but it is well understood nowadays that any fluid introduced into the auditory meatus must be thoroughly sterilised, as well as the instrument used for the injection.

Pure boiled water answers very well for the merely mechanical effect of an injection of this kind, but it is customary to add certain substances for antiseptic purposes. I do not propose to weary the reader by a

list of the innumerable mixtures employed for irrigation of the ear; but as it is of importance to keep a few of them on hand, in order to be able, when one appears to lose its effect, to substitute another I shall mention those which practical experience has shown to be most efficacious:—

There are in the first place the three antiseptic solutions generally used, arranged in the order of their potency; the saturated boracic acid solution, the 1 per cent. carbolic acid solution, and the 1 : 1,000 mercury perchloride solution. These are indeed sufficient for the large majority of cases, provided one knows how to handle them and takes into account the peculiar deficiencies of each, viz., the weakness of the first, the irritating local action of the second, and the toxicity of the third.

A large number of other antiseptic substances are also employed, which, however, present no other advantage over those mentioned above than that they are new, and may occasionally replace them when a change is desired. The principal ones of these are: creolin (1 or 2 : 1,000), lysol (1 or 2 per cent.), phenosalyl (1 per cent.), resorcin (from 1 to 4 per cent.), salicylic acid (from 1 to 4 : 1,000), hydrogen peroxide, pure or diluted with from one to five times its volume of water, oil of turpentine (20 drops in one litre of water, Politzer). This, I think, is more than will ever be needed for varying the treatment at pleasure.

Whatever solution may be used, it is of the greatest importance to dry the auditory meatus well after each irrigation, either by insufflation of warm air, or with a cotton swab attached to a metal probe or held by a pair of forceps. It need hardly be stated that these tampons should be sterilised, that is to say, be passed through the disinfecting stove and preserved in closed glass jars, or flamed by the method described by Lermoyez and Helme, which consists in steeping the cotton swab in a saturated solution of boracic acid in alcohol and setting fire to it, the boracic acid preventing the cotton from burning. After a few seconds, the flame is extinguished, and the swab is then completely sterilised, or at any rate its surface is rendered sufficiently aseptic to do away with the danger of introducing into the meatus any germ of secondary infection.

Of late, however, irrigation of the middle ear has been the object of very unfavourable criticism. In the first place, the objection has been made that this irrigation is doomed to be incomplete, as it does not reach either the attic or the mastoid cells, and that on the whole it is only a surface irrigation, affecting principally the auditory meatus and but very little the deep cavities. This argument is not without force, for it is certain that a jet of liquid, however forcibly applied, can never be made to wash out thoroughly a blind duct, especially when the cavity is irregular. What is the result, for instance, of trying to wash out a bottle, without turning it upside down, simply by means of a continuous jet, passing through the neck? For irrigation of the ear to be really efficacious it would be necessary to have a counter-opening so as to permit the fluid to pass through it from one end to the other, and thus to clean out the contents. An attempt has been made to obtain this result by injecting through a catheter or a Weber-Liel sound introduced into the Eustachian tube, a quantity of fluid, passing through the tympanum and out through the auditory meatus. The attic is reached by inserting through the opening in the tympanic membrane one of Hartmann's bent catheters. In spite of these artifices, however, it must be admitted that the results of irrigation of the ear are not entirely satisfactory. It has even been alleged that this manœuvre merely results in driving the germs existing in the auditory meatus into the tympanum, and is therefore so dangerous that it is better not to employ it. Politzer long ago proposed to replace the liquid by a current of gas, and clean out the tympanic cavity with an air douche through the Eustachian tube. This measure, however, to which Gruber has long objected, has in its turn been accused, not only of removing much less pus from the tympanum than is generally supposed, but also of introducing into it microbes from the nasal cavities and pharynx. The opinion is therefore gaining ground that

no attempts should be made at cleaning out the tympanum either with water or air, simply "replacing all that" (Pes and Grad-nigo) by aseptic dressing of the auditory meatus. This dressing itself, like irrigation of old, tends to become more and more simple. Formerly it was the rule, after washing out and drying the ear, to blow in an antiseptic powder, boracic acid having been much used for this purpose on the recommendation of Politzer. The objection made to it, that it forms a paste and thus prevents the pus from escaping, does not hold unless it be employed in too large quantities. Very little should be used, only just enough to barely whiten the wall of the canal. The feeble antiseptic power of boracic acid has led to its being replaced by other, more active, substances, such as iodoform, which is indicated especially in tuberculosis, in spite of its disagreeable odour, aristol, dermatol, and salol. Like irrigation, however, insufflation of powder is gradually going out of fashion. A strip of iodoform or simply sterilised (Hamon du Fougeray) gauze, which is introduced to the farther end of the auditory meatus and drains the tympanic fistula, on top of this a layer of gauze, and, lastly, a bandage to keep it in place, such is the modern dressing of suppurative otitis, described by Pes and Gradnigo under the name of the "rational treatment."

The antiseptic dressing represents only an armed expectation, so to speak, or a respite accorded to the otorrhœa before combating it by operative measures. Before resorting to this *ultima ratio* of treatment, however, another series of local measures is usually tried, which are more potent than a simple dressing, but less aggressive than operation, being a sort of compromise between these two extremes. This is instillation of astringent or caustic fluids, constituting the modifying treatment, the aim of which is to change the structure of the secreting surfaces, to reduce the hypertrophied mucosa, to check its granulation, and possibly even to facilitate detachment of sequestra and cleansing of the carious surfaces. Among chemical caustics used in otology, silver nitrate is the one most frequently employed, either in strong solutions, graduated from 2 to 10 per cent., or in the form of a stick, or rather a small lump attached to the end of a metal rod. It unquestionably possess the property of reducing a too exuberant mucous membrane, and checking the production of fleshy granulations. The only drawback is the fact that it sometimes determines excruciating pain, especially when it touches a denuded bone or passes into the mastoid cavities. It is necessary, therefore, to gradually lead up to the use of strong solutions of this caustic, and to always take the precaution of first applying cocaine to the mucous membrane. To get the full effect of the remedy, it is not enough to use two or three drops, but the auditory meatus should be completely filled with fluid, the head of the patient being held in a suitable position, so as to produce the effect of a genuine ear bath of from two to ten minutes' duration. The pinna and the skin in the neighbourhood should be coated with vaselin (Lermoyez), in order to do away with the black stain which the light would otherwise produce in the deposit formed by the reduced silver.

The modifying substance employed for instillation in the ear are without number, those most frequently resorted to being alum (2½ per cent.), zinc sulphate (1 per cent.), aluminum aceto-tartrate (1 per cent.), carbolic acid (3½ per cent.), phenosalyl (10 per cent.). As vehicles are used water, glycerin, oil of vaselin, or alcohol, the last of which possesses modifying properties of its own which have suggested the use of pure alcohol for this purpose. In a recent article Dr. Couetoux has discussed certain details of alcohol dressing, showing that it exerts its action less on the tympanum than on the auditory meatus, the inflammatory swelling of which it rapidly reduces. Moreover, the susceptibility of the meatus, and not that of the tympanum, prevents employing alcohol of greater strength than 95 degrees, which Dr. Couetoux recommends for use in all dressings of the ears. He also calls attention to the fact that heat is an indispensable factor for the auditory meatus to be able to bear alcohol dressings, and he therefore advises in such cases

invariably to warm, not only the fluid, but also the ear of the patient.

Whatever their effect on the diffuse lesions of the mucous membrane may be, these instillations are powerless when it is necessary to destroy granulations or polypi, which frequently form in the tympanum in the course of an old-standing otorrhœa. Though alcohol, as Politzer claims, sometimes gets the better of granulations of small size, its action is so slow as to necessitate in most cases the use of more active substances, such as a bulb of silver nitrate or chromic acid at the tip of a probe, iron perchloride in its natural state, liquid, or crystalline trichloroacetic acid, and, in the tuberculous form of the disease (from 10 to 50 per cent.) or pure lactic acid. Any of these caustics destroys in a comparatively short time the granulations in question, but nothing equals the prompt and efficacious results of applying the galvanocautery, or, if the polypus is accessible, removing it by dividing the pedicle with Wilde's polypus snare or Politzer's cutting ring. When the tumour is sessile, it should be removed by abrasion with a curette. To complete the exeresis and prevent the reproduction of the tumours, it is usually advisable after the operation to cauterise the stump, but in spite of this precaution, recurrences not infrequently take place.

Surgical Treatment of Otorrhœa with Osseous Lesions.—Should the foregoing measures, in spite of having been systematically employed for a sufficient time, fail to afford relief, it is useless to continue a treatment which has proved its inefficiency, and recourse should therefore be had without delay to surgical measures. It is of the greatest importance, however, to be able to determine as far as possible the opportune moment when the treatment of otorrhœa should cease to be medical and become operative. The line of demarcation is indeed very faint, and the modern tendency toward operation at all hazards has made it still more uncertain. Taking everything into consideration, however, I think surgical intervention is indicated.

1. In all cases of old-standing otorrhœa, in which no improvement has been obtained by antiseptic treatment.

2. When the probe reveals the existence of osseous lesions, denuded spots or sequestra, either in the walls of the tympanum or the auditory ossicles.

3. When a cholesteatoma is detected or suspected.

4. When hearing is completely lost, so that no further damage can be wrought in this direction, the object of operation under such circumstances being to stop persistent suppuration, as in any other bony region.

5. Lastly, when there is the slightest symptom pointing to encephalic complication, intervention is not only justifiable, but imperatively called for.

It is not enough, however, to know when, but also how, to intervene. The methods employed in operations on this region are so numerous as to render a choice between them extremely embarrassing. Theoretically the operation must be adapted to the existing lesions, and should proceed according to a plan, carefully made up beforehand on the basis of the diagnosis. If the malleus or incus is necrosed, the diseased bone should be extirpated; if there is caries of the walls of the tympanum, they should be curetted; if mastoid lesions exist, trephining should be resorted to; if all the cavities are involved, they should be freely opened, &c. All this is very good, were it always possible to determine beforehand what particular anatomical lesions will be found in a given case of otorrhœa, but nothing is more uncertain, and one must always expect surprises in operations on the ear.

In the absence of precise data to go by, otologists have therefore lately in the treatment of otorrhœa followed a sort of scale, made up of a series of operations of increasing importance and gravity, from which a choice is made according to the persistence of the affection and the nature of the unsuccessful measures previously employed.

As a rule, the first measure resorted to is removal of the auditory ossicles, as soon as caries is suspected. This operation is not a difficult one, when performed through the auditory meatus (Poltzer, Miot), nor does it imply

any great risk, as hearing is usually completely lost previous to the intervention.

When this first attempt remains without result, another step is taken, and the walls are broken down, the anterior wall of the attic being almost invariably the first point of attack. Stacke has recently made a great improvement upon the old method of performing this operation. Instead of proceeding through the auditory meatus, he detaches it, together with the pinna, by a retro-audicular incision, thus reaching to the external wall of the attic, which he removes with a gouge or chisel, while a special "protector," introduced into the attic, prevents all danger of damaging the fenestra ovalis, promontory, or facial nerve by slipping of the instrument.

When the manner of making this large opening through the bony substance had been discovered, it became much easier than it had ever been before to observe what was going on in the cavities of the ear. It was thus unexpectedly found that the lesions of chronic otitis are much more extensive than had hitherto been supposed, the lesions of the bone involving not only the attic, but also the aditus and antrum. If these lesions were followed up by opening the external wall of the petro-mastoid canal, they led in the great majority of cases into the antrum, and thence into the mastoid cells. Stacke himself, for instance, could only in 2 out of 33 operations of this kind, limit his intervention to the attic, being obliged in the other 31 cases to gradually proceed as far as the mastoid process. Simply opening the attic, which was the first step aimed at, is therefore, as a rule, merely a preliminary step to the subsequent operation.

Under such circumstances it may be pertinently asked why, if one is almost certain in commencing with the tympanum to be obliged to continue until the deep strata of the mastoid process are reached, the start should not be made in the latter region and the antrum, which is very likely to be diseased, directly attacked, following the lesions, if need be, back to the tympanum? Such is, in short, the principle of the radical intervention, advocated by Schwartze, Küster, Zaufa, Luc, and Holmes, which appears destined to become the method *par excellence* of treating otorrhœa in the future. While Stacke in reality attacks merely the tympanic cavity, proceeding as far as the mastoid process only in a case of absolute necessity, the object of the method described by Luc, in 1894, under the name of "free opening of the cavities of the middle ear," is to penetrate at once into the antrum, excise the wall of the aditus, and finally reach the attic from the outside, everything being laid open, because it is known beforehand that all the parts are diseased. It is needless for me to call attention to the greater precision and efficacy of an operation which starts ahead of the lesions and follows them up to their source, or to the superiority, from a surgical point of view, of an intervention in which the operator knows beforehand where he is going, over one in which he starts from the tympanum, without being able to tell where he is going to stop.

THE HYSSOP:

ITS BOTANICAL HISTORY; ITS SYM-
BOLISM; ITS TOXICOLOGY AND ITS
THERAPEUTICS.

By JOHN KNOTT, M.A., M.D.,

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(Concluded from page 5.)

The more practical "Herbal" of William Salmon gives the following account of the same plant:—

"Of Hyssop Common.

"I. The Names.—It is called in Arabick, Cyfe, Javes, Jufa, in Greek, *ῥύσσωπος*, in Latin, *Hyssopus*, in English, *Hyssop*.

"II. The Kinds.—There are two principal Kinds hereof, viz., 1. *ῥύσσωπος κοινός*, *ῥύσσωπος ὑψηλός*, *Hyssopus Vulgaris*, Our Common Hyssop. 2. *ῥύσσωπος ἁγίος*, *Hyssopus*

infrequens, *Hyssopus incelebris*, vel *insolitus*, *Hyssop* Strange, and not *Vulgar* or *Common*, of which in the next Chapter.

"III. The Kinds.—Of Our Common Garden *Hyssop* there are only two Kinds, viz., 1. *Hyssopus Vulgaris*, *Hyssopus Arabum*, Our *Vulgar* or *Ordinary Hyssop*. This *Hyssop* is not the *Hyssop* of *Dioscorides* and other Greek Authors, as all our modern Botanists do acknowledge, except *Matthioli*, who earnestly contends that Our Garden *Hyssop* is it, against all reason; nor do any of our Herbarists know (as far as I can find) what the true *Hyssop* of the Greeks was. As for Our Common Garden *Hyssop*, it is certainly the true *Hyssop* of the Arabians, and so we take it. 2. *Hyssopus Arabum Floribus rubris vel albis*, *White* or *Red Flowered Hyssop*.

"VI. The Descriptions.—The first, or the *Vulgar Ordinary Hyssop*, has a Root which is somewhat woody, with many thready strings thereat; it is a small bushy Plant, which rises up with many woody but tender Branches, something more than a Foot high, on the Stalks and Branches whereof are set at certain distances several small, narrow, and long green Leaves not dented at all on the edges; at the tops of the Stalks and Branches grow bluish purple gaping Flowers in spiked Heads, one row above another, after which follows the Seed, which is small and blackish; the whole Plant is of a vigorous or strong, sweet, pleasant smell.

V. The second, or *White* or *Red Flowered Hyssop* They have a Root like the former, but are scarcely to be distinguished in their form and manner of growing from the Common Garden Kind (of which this is a sort) the chief difference is, that they do both usually bear white or red Flowers, all on one side of the Spike, yet continue not constant in that form, but change into the form of the former Common Kind, and so become (as it were) the same Plant, and after that change not to be discerned therefrom

"VI. The Places.—They grow with us only in Gardens, and that through the whole Kingdom of England and Ireland, but they grow wild in Arabia, and other hot Countries, as also on the Hills of Romania, about Verona, and near unto Mount Baldus.

"VII. The Times.—They Flower in the Summer Months, viz., in June and July, and their seed is ripe in he beginning or middle of August.

"VIII. It is hot and dry in the third degree, *Aperitive*, *Absterive*, *Astringent*, *Anodyn*, *Carminative*, *Digestive*, *Diuretick*, it incides, rarifies, and makes thin; it is *Stomackick*, *Pectoral*, *Cordial*, *Splenetick*, *Nephritick*, and *Arthritick*, *Emmenagogick*, *Alexipharmick*, and *Analeptick*.

"IX. The Specification.—It is peculiar against *Asthma's*, *Coughs*, *Colds*, *Catarrhs*, *Wheezing*, *Shortness of Breath*, difficulty of breathing, cures *Consumptions*, *Strangury*, *Falling Sickness*, and *Green Wounds*.

"X. The Preparations.—You may prepare therefrom 1. A Liquid Juice. 2. An Essence. 3. A Decoction in Wine or Water. 4. A Lohoch or Syrup. 5. A Powder. 6. Pills. 7. A Lotion or Gargarism. 8. An Oil by Decoction. 9. A Ba'sam or Ointment. 10. A Cataplasim. 11. A Distilled Water. 12. A Spirituous Tincture. 13. An Acid Tincture. 14. An Oily Tincture. 15. A Saline Tincture. 16. A Spirit. 17. An Oil Distilled. 18. Powers. 19. An Elixir. 20. A fixed and Volatile Salt. 21. A Wine.

THE VIRTUES.

"XI. The Liquid Juice.—Mixed with Honey and taken it kills Worms in the Belly, and helps *Asthma's*, *Coughs*, *Colds*, *Wheezing*, *Shortness of Breath* and other Distempers of the Lungs, caused by a plenitude of Humors. Dose from one spoonful to three, Morning and Night.

"XII. The Essence.—It has all the Virtues of the Juice, besides which it is excellent against the *Falling-Sickness*, *Agues*, *Catarrhs*, or *Distillations of Rheum* upon the Lungs, and other parts; it amends and cherishes the Native Heat, and color of the Body, &c., and is a powerful Remedy against the *Colick*, *Strangury*, obstruction of the Terms in Women, *Poyson*, the bitings of mad Dogs, Serpents, and other Venomous Creatures; it cuts tough Flegm, and causes expectoration. Dose

two or three Spoonfuls in the Distilled Water, or some other proper Vehicle.

"XIII. The Decoction in Wine or Water.—It has all the Virtues of the Juice and Essence, but nothing near so powerful, and therefore may be given Morning, Noon, and Night to six or eight Ounces, sweetened with new Honey; if Rue and Honey is boiled with it, and so drunk, it stops *Catarrhs* upon the Lungs, and has the other Virtues of the Juice and Essence; if the Decoction, Juice, or Essence, is mixed with *Oxymel* it purges gross Humors by Stool, and kills Worms in Children; if any of these three Preparations are mixed with pulp of Figs and Sal Nitre it loosens the Belly and works downwards also; if either of them are mixed with Juice of Garden Cress and Blew Flower de luce Roots, or powder of the said Flower de luce Roots, in a fit proportion, this mixture will purge the Bowels yet more forcibly, carry off the causes of the *Colick*, cure the *Yellow Jaundice*, *Dropsie*, *Obstructions of Liver*, *Spleen*, and *Womb*, and restore the true Color of the Skin, this more especially if it is taken twice or thrice a week, as the body can bear it.

"XIV. The Lohoch or Syrup.—Take of the clarified Juice two Pounds, of choice Honey four Pounds, mix, and boil to the consistence of a Rob or Quiddony. It has the Virtues of the Juice, Essence, and Decoction, and may be taken three, four, five, or six times a day, or more, as the nature and reason of the Disease requires; it causes an admirable expectoration of the morbid matter out of the Bronchia of the Lungs; takes a little of it at a time with a small little Spoon, and let it distil down the Throat gradually.

"XV. The Powder.—It is made of the Leaves, Heads, and Flowers; strewed upon Green Wounds, it presently heals them, upon old running Ulcers it cleanses, dries and heals them also; applied with powder of Cumin Seed, Salt, and Honey, it is good against the bitings of Vipers, Rattle-Snakes, Mad Dogs, and other venomous Creatures; given inwardly to one Dram, or Dram and half, it gives ease in the *Colick*, provokes the Terms, and opens the obstructions of the Urinary parts; it causes to break wind, and prevails against cold fits of Agues.

"The Pills.—Take *Hyssop* in Powder, Male Peony Roots in powder, of each two Drams, Castoreum in powder one Dram, Horehound in powder, *Assafoetida*, of each half a Dram, Crystals of Luna in powder a Scruple, with Rob of *Hyssop* (made *per se* without Honey), q.s. mix, and make a mass of Pills, for seven Doses, to be given every night at Bed time: This is said to be a specific and effectual Remedy against the *Falling-Sickness*, to be repeated every New and Full Moon so long till the Cure is completed: These Pills cure also a vehement Headache, tho' of very long standing, and are prevalent against a Vertigo.

"XVII. The Lotion or Gargarism.—Take *Hyssop* four good handfuls, White or Red Port Wine three Pints, Sal Nitre an Ounce, mix, and boil for a quarter of an hour, then drain off the clear. It is a singular good thing against the Quinsie, or any soreness of Throat or Mouth, it abates the inflammation of the Throat, and discusses the swelling thereof, being often gargled therewith; it takes away inflammations in other parts of the Body, as also black and blew spots and marks, which are occasioned by Falls, Blows, or Bruises; if Wine Vinegar is used to make the Lotion with instead of the Wine, it will cure the Toothache, and the fumes thereof being received thro' a Funnel into the Ears eases their pains, and abates an inflammation if any is present, and also takes away their singing noise.

XVIII The Oily Decoction or Insolation.—Being anointed upon the Head it is said to kill Lice and Nits therein, and take away the itching: taken inwardly to one or two ounces mixed with Honey it opens obstructions of Stomach and Lungs, and causes the pituitous matter to pass off through the Guts; anointed upon any part swollen and pained thro' cold, it eases the pain and discusses the swelling.

"XIX. The Balam or Ointment.—Being applied they quickly heal any Simple or Green Wound in the Hand, or other parts of the Body; applied also to old running Sores and foul Ulcers they cleanse, dry, and heal them quickly, more especially if the Powder of the Herb

afore named be also strewed upon the same; the Balsam applied upon any part pain'd with the Gout gives ease in the pain, and by continuing the application in a short time cures it.

XXI. *The Cataplasm.*—Made of the Green Herb by bruising, adding also thereto Sugar and Salt, with a few Crumbs of White Bread, and applied, it is admirable to discuss any recent simple contusion, or heal any simple Green Wound, in what part of the Body soever.

XXI. *The Distilled Water.*—It has the virtues of the Juice, Essence, and Decoction, sweetened with Sugar or Honey, and so taken from two ounces to four ounces, but it is mostly used as a Vehicle to convey the other Preparations down in; outwardly used sweetened with Honey it is of good use to cure sore and running eyes.

XXII. *The Spirituous Tincture.*—It is Cephalick, Neurotick, Stomatick, and Pectoral, it is good against Wind in the Stomach, gives ease in the Colick and gripings of the Guts, and sweetened with Honey it eases the vehemency of the Cough, and causes Expectoration; it is good against Vapors from the Womb, Fits of the Mother, and the Falling-Sickness. Dose one Spoonful in the Morning fasting, another an Hour before Dinner, and the like at Night going to Bed, in the Distilled Water.

XXIII. *The Acid Tincture.*—It is good against the Plague, and all sorts of malign and pestilential Diseases, it resists Poyson, and is efficacious against the bitings of mad Dogs, Vipers, and all other kinds of Venemous Creatures; it cleanses the Stomach, strengthens it, and causes a good Appetite and Digestion, suppresses Vapors, and resists Hysterick Fits; it powerfully opens obstructions, and attenuates thick and poor Humors which clog and stuff the Viscera, causing the same to be carried off by Stool and Urine. Dose so many drops as to make the Vehicle pleasantly sharp.

XXIV. *The Oily Tincture.*—It opens the obstructions of the Urinary parts, as also of the Womb, provokes Urine and the Terms, expels Wind powerfully, and gives ease in the Colick, gripings of the Guts, Stone, Gravel, Strangury, &c. Dose from ten to twenty drops in any proper Vehicle Morning and Night; it gives ease in the vehement pains of the Back, and outwardly used is food against Convulsions, Cramps in any particular part of the Body, as also the Palsie and Gout, &c.

XXV. *The Saline Tincture.*—Inwardly taken in a Glass of White Port Wine from half a Dram to a Dram, or Dram and half, it is prevalent against the Strangury, and causes a Pissing freely; outwardly used it is food against Scabs, Pimples, breakings out, Tettars, Ringworms, Scurf, Morpew; Tanning of the Skin, sunburning, Yellowness, and other deformities thereof, the Skin (after being first wash'd clean with warm Water) being well bathed therewith Morning, Noon, and Night.

XXVI. *The Spirit.*—Being dulcified with double refined Sugar it is a most excellent Stomatick and Cordial, it expels Wind, gives ease in the Colick and gripings of the Guts, it prevails against Fainting and swooning Fits, Sickness at Heart, and other Distempers of the Stomach and Præcordia. Dose from half to one Spoonful in Canary, or some other Wine or proper Vehicle.

XXVII. *The Distilled Oils.*—It is a specifick against an old inveterate Cough, Catarrh, and Asthma, it cures the Colick to a Miracle, expels Wind powerfully, and cures Convulsions, Lethargies, Vertigo, and the Palsie after a singular manner; it admirably strengthens the Nerves and Brain, and is good against all cold and moist Diseases affecting these parts, let them come from what cause soever; it eases the Headach coming by reason of cold, and is a singular Antidote against the Gout, being both inwardly taken and outwardly applied; it is powerful against Agues, as also against the Headach, Megrim, Vertigo, Carus, Lethargy, and other Diseases proceeding from cold and moisture, but more especially it is said to be a peculiar remedy for the Falling Sickness, tho' in Persons past their Minority, and who are advancing towards their middle Age; in the Palsie the Back Bone is to be Anointed these, with Morning and Night, rubbing it well in, and inwardly it is to be given from four drops to ten, fifteen, or twenty, according as the Patient is in Age and Strength,

and the Dose to be repeated Morning and Evening so long as need requires; let it be dropp'd into White Sugar, with which it is to be well mixed, then add to it the Vehicle you design to give it in, and so let the Patient drink it.

XXVIII. *The Potestates or Powers.*—They have also the Virtues of the Distilled Oil, and are much more thin and penetrating, sinking into the Flesh as fast as they are put on; they are to be outwardly used in the same manner as the Oil, and to the same parts in the same cases, and likewise to be inwardly given Morning, Noon, and Night, from thirty to eighty or an hundred drops, in a Glass of Wine, or other proper vehicle.

XXIX. *The Elixir.*—The Virtues hereof are just the same with the Distilled Oil and Powders, and to be used also outwardly and inwardly in the same manner, saving that the Dose of the Elixir is only from twenty to sixty in Wine, or some fit Vehicle; given in sherry or Madeira Wine to sixty drops or more in Pleurisie it gives present ease, and in a little time after a perfect cure; in particular also it is a very excellent thing to kill worms in children.

XXX. *The Salt Fixed and Volatile.*—They are both Alcalies, and so absorb acids, infallibly cure the pain of the Stomach, tho' inveterate and never so vehement, they have been given with good success in all sorts of Colicks, they open obstructions of all the Viscera, but more particularly of the Spleen, Reins, and Womb; they suppress Vapors, prevail against Hysterick Fits, conquer Hypochondriack Malancholly, deobstruct the Urinary passage, and give present ease in the Strangury, causing the Patient to piss plentifully and easily, and being continued for some convenient time cure the Yellow Jaundice. Dose, from ten to twenty grains, or more, in a Glass of generous White Port Wine Morning and Night, or often, in the daytime if need so require.

XXX. *The Wine.*—Take Hyssop chopped small a handful, choice ripe Figs slit three ounces, White Sugar candy an ounce and half, Muscadine a Quart; boil together till half a pint is consumed, then strain out and keep it for use. Dose, three spoonfuls Morning and Evening against an old Cough; it causes the tough Flegm to be more easily expectorated, gives ease to the Strangury by opening the passages of the Urine when they are stopped; and provokes the Terms in Women when preternaturally stopped.

And even the various kinds of wild Hyssop had, in addition to the common family virtues, special praiseworthy medicinal qualities, each after its kind. It now looks strange that a plant which enjoyed so high a reputation in past ages could have dropped below the range of therapeutic vision as to be seldom heard of, except on an occasion like the one referred to in the opening paragraph of this paper, when its use only afforded the most disastrous results. It is somewhat better known, however, on the Continent. Baillon (*Botanique Médicale*) tells us that: "Ses feuilles et ses sommités fleuries, très odorantes, sont employées comme stimulantes, pectorales, sudorifiques et détersives; on les adjoint à certains mélanges purgatifs pour leur donner de l'arome. C'est un condiment pour quelques personnes." And this illustrious medical botanist goes on to inform his readers that "L'idée que cette plante est purifiante repose sur ce fait que ses branches rameuses servaient de goupillons pour répandre les eaux lustrales."

The application of the leaves and tops of this plant to the sprinkling with lustral and consecrated waters in religious rites has been brought down with Christianity on account of its prominent Scriptural celebrity. Yet the identification of the *Hyssopus officinalis* with the terms rendered "hyssop" in the various texts of Holy Writ is based upon opinion which requires corroboration. So that it may some day be demonstrated that the whole reputation of Hyssop originated in what is known to logicians as a "fallacy of equivocation." The sprinkling with "a bunch of hyssop" commanded by the law of Moses; its intimate association with the sacred cedar-wood and scarlet in the Jewish ceremonies; the Biblical testimony that it elicited the special comment of King Solomon in the flower of his might and his wisdom; the piteous appeal of the penitent David in his affliction, "purge me with hyssop and I shall be clean"; the

incident on Mount Calvary when "they filled a sponge with vinegar and put it upon hyssop"; the thesis defended by some mediæval theologians that the "*Crown of thorns*" was formed of the wild hyssop; and the fact that mediæval astrologers placed the hyssop under the special guardianship of Jupiter—all combined to throw a glamour around its name. In the present state of knowledge we can only say of hyssop that its identification with the plant so named in our translations of the Bible is, to say the least, doubtful; that its medicinal advantages are questionable, and can be more reliably obtained from other sources; while its mischievous effects have been satisfactorily demonstrated.

Clinical Records.

WESTMINSTER HOSPITAL.

Case of Hepatic Multilobular Cirrhosis.

Under the care of Dr. MURRELL.

W. P., æt. 43, was brought to the hospital on November 13th, 1899, with a history of having passed blood with his motions. It was noticed that he was slightly jaundiced, and on a cursory examination it was found that his liver extended about two inches below the umbilicus. Soon after admission he passed two motions consisting of a little light-coloured fæces mixed with about a pint of bright-red blood. It was thought that he might have cancer of the liver, secondary to a malignant growth in the rectum. A rectal examination was made under an anæsthetic, and a mass of internal piles was detected, but nothing presenting the signs of a malignant growth. The prostate was enlarged, and the question of that being the primary seat of the disease was discussed. This view was negatived on the ground that cancer of the prostate is a disease of late life. A more careful examination was then made of the liver, and it was found that it was uniformly enlarged and that no nodules could be detected. The diagnosis of hypertrophic cirrhosis was then definitely made. The patient at first denied any alcoholic history, pointing out that he had held a responsible position for many years, and urging that if he had been addicted to drink his services would not have been retained. Later on he admitted that he had been in the habit of taking a good deal of beer varied with rum when the day happened to be cold or damp. He had had three attacks of gout, but stated that he had not suffered from syphilis. It was quite clear that he was perfectly well up to four months before admission, when he first noticed blood in the motions. He had continued in active employment until within seven weeks of admission. His temperature was always above normal, varying from 99.6 in the morning to 102.8 in the evening. The urine had a sp. gr. of 1025, and contained bile pigments. The hæmorrhage from the bowels was checked by rectal injection of liquor hamamelidis. He was ordered large doses of iodide of potassium with inunctions of calomel ointment night and morning. His liver rapidly decreased in size until the lower edge was well above the umbilicus. This was followed by ascites, and the patient rapidly passed into an apathetic condition with increased jaundice. He died on December 14th after an illness of about five months' duration.

At the post-mortem examination (made by Dr. Lazarus Barlow) the liver was found to weigh 4 lbs., 11 ozs. It was wrinkled on the surface and tough on section. The colour was not yellow as is ordinary with cirrhosis, but slaty. On microscopical examination it was found to be a very fine framed variety of multilobular cirrhosis. The gall-bladder was dilated and pressure failed to expel any bile out of the duodenum. The common bile duct, when slit up was found to be contracted, but appeared normal. The spleen weighed 9 ozs., was firm and of a brightish red colour; capsule thickened. The kidneys were normal, except that the left was provided with two ureters. The cæcum (filled with gas) was dilated into a pouch 8 ins. long and 8 ins. or more in circumference.

Transactions of Societies.

OBSTETRICAL SOCIETY OF LONDON

MEETING HELD WEDNESDAY, JANUARY 3RD, 1900.

MR. ALBAN DORAN, F.R.C.S., President, in the Chair.

CAST OF THE UTERUS OF PROBABLE INFLAMMATORY ORIGIN.

DR. T. W. EDEN showed a cast of the uterus passed by a patient, who had been confined eighteen months previously. She had no dysmenorrhœa; she usually menstruated about every six weeks, and the cast shown had been passed after forty-eight days' amenorrhœa. It was rather larger than would be the cast from a normal-sized uterus. It showed evidence of endometritis, and was probably of inflammatory origin; microscopically there was neither epithelium nor glandular tissue, but there were numerous leucocytes. It showed a few cells like decidual cells; it had been shown that the presence of such cells in the endometrium was characteristic of a former but not necessarily recent pregnancy.

THE PRESIDENT pointed out that on such a specimen important medico-legal questions might depend, especially with regard to its significance as indicative of pregnancy. Mr. Taylor, of Birmingham, and others had shown that there was no true distinction to be drawn between the cast from a case of membranous dysmenorrhœa and one from a case of extra-uterine gestation.

DR. C. HUBERT ROBERTS asked whether Dr. Eden drew any distinction between a case of this kind and one of membranous dysmenorrhœa. On the latter subject there was still much confusion, but the condition might perhaps be regarded as inflammatory. This view was taken by several authorities.

MR. TARGETT agreed with Dr. Eden that the main characteristics of this specimen were those of inflammation; but it might do quite well for an example of membranous dysmenorrhœa. The mere presence of decidual cells did not point to much one way or the other. He thought that Mr. Taylor went too far in saying that the casts of membranous dysmenorrhœa and extra-uterine gestation were indistinguishable; his own view was that in the majority of cases the difference between the two could be made out.

DR. EDEN, in reply, agreed with Mr. Targett that the cast of ectopic gestation could be distinguished from that of membranous dysmenorrhœa. The specimen differed from the latter condition in two points; first, the patient had no dysmenorrhœa; and secondly the cast was extruded whole, whereas in membranous dysmenorrhœa the membrane usually came away in shreds.

ECTOPIC GESTATION: MACERATED FŒTUS REMOVED TWO MONTHS AFTER TERM.

THE PRESIDENT showed this specimen, removed two months after a spurious labour. The gestation sac was formed mainly by the posterior layer of the left broad ligament; and the pregnancy was the type recently described by Mr. Taylor as "posterior ligamentary" or retroperitoneal. A fæcal fistula complicated the convalescence; but the patient recovered.

DR. CULLINGWORTH said that he had reported two or three cases of this kind. Circumstances were often unfavourable to the recovery of these patients, and Mr. Doran was, therefore, to be congratulated on his success. In one of his own cases there were three distinct communications between the sac and the bowel, and the patient lived only three days after operation. He would ask why in Mr. Doran's case the placenta was not removed at the time of operation? When the fœtus had been dead some time, the removal of the placenta was usually easy, and unattended by important hæmorrhage, as he found in one of his cases operated on four weeks after the death of the child.

DR. JOHN PHILLIPS had operated on two such cases, and had another under observation, whose conception dated twelve months back. In both his operations he removed the placenta without difficulty, and he believed

that this was the general experience in cases dealt with three or four months after the spurious labour. Both his patients recovered.

Dr. HANDFIELD-JONES had also had two cases. One was a macerated foetus; he did not remove the placenta, but stitched the edges of the sac to the wound. She did well. In the other case the child was living. He dealt with the sac in the same way, but she died of sepsis two weeks later. At the autopsy it was found that the placenta was intimately attached to the iliac vein; any attempt to remove it at the time of operation would probably have resulted in death from hæmorrhage from rupture of the vein. No hard and fast rules could therefore be made on the mode of dealing with the placenta.

The PRESIDENT, in replying, added that the sac was a distinct one, whose edges could be secured to the wound. It was not, therefore, one of those spurious sacs formed by adhesions, such as occurred in a case of primary abdominal pregnancy. They owed the differentiation of anterior and posterior ligamentary pregnancy to Taylor. The cases where the sac contents were fetid seemed to be always those of posterior ligamentary pregnancy; in the other type the tendency was rather to the formation of a lithopædion. In reply to Dr. Cullingworth, he could not remove the placenta, because, owing to its extensive attachment, removal would have involved the dissecting up of the whole rectum.

FOUR CASES OF RUPTURE OF THE UTERUS.

Dr. H. SPENCER read notes of four cases of rupture of the uterus successfully treated by packing the tear *per vaginam* with iodoform gauze. They are the only cases in which he has adopted this method of treatment, and the only cases which he has known recover. All the others (about eight in number) have died in a few hours from shock and hæmorrhage or in a few days from sepsis. Twice he has performed abdominal hysterectomy with a fatal result. After quoting some remarks he made in the "Obstetrical Transactions" for 1897 upon the great danger of the operation of abdominal hysterectomy in patients shocked by rupture of the uterus, the author expresses the belief that the mortality of rupture of the uterus may be lessened by the use of gauze packing. Having alluded to the advocacy of gauze packing by others, he expresses his own views, for the purpose of discussion, as follows: In the treatment of rupture of the uterus—(1) *Abdominal section* is rarely required, and almost solely in cases where the foetus has passed completely or in great part into the peritoneal cavity. It should be performed rapidly under local infiltration anaesthesia, and should be followed by flushing of the peritoneal cavity, with normal salt solution and by suture of the tear if possible, or, if this be not possible, by packing the tear with iodoform gauze and draining by the vagina or abdomen. (2) *Abdominal hysterectomy* is hardly ever necessary; when the broad ligaments are so much damaged as to endanger the vitality of the uterus vaginal hysterectomy should be performed. (3) All incomplete tears implicating the broad ligament and most complete tears should be treated by packing the rupture *per vaginam* with iodoform gauze after removing clots and fluid blood.

The PRESIDENT drew attention to the fact that when using iodoform gauze absorption of iodoform might lead to a very rapid pulse, which might be confusing as leading to a suspicion of sepsis. This might occur also after ovariectomy when iodoform gauze drainage was used.

Dr. HORROCKS considered that cases of rupture confined to the cervix and broad ligament were much less serious than those opening into the peritoneal cavity. He had met with a fair number of cases of rupture of the uterus: one was a tear from the cervix into the peritoneal cavity, the result of precipitate labour; he put in two stitches and packed with sal alembroth gauze, which was renewed under an anaesthetic every twelve hours for three days, then once a day. Two other cases were treated successfully by packing. In a fourth case the rupture resulted from an attempt to remove a piece of placenta, and was situated in the anterior uterine wall. He opened the abdomen and stitched the tear. The patient recovered, although the wound broke down

on the tenth day from a fit of coughing. In an aseptic case he could see no objection to sewing up the wound; but he did not think that hysterectomy was advisable in any case. Would Dr. Spencer insist on the use of iodoform gauze? It seemed to him that sterilised gauze would answer equally well.

Dr. LEWERS recounted a case of rupture of the uterus in which the tear extended through the posterior wall into the peritoneum. The rent was packed with iodoform gauze, and though the condition was very critical for ten days, the patient recovered. He had used iodoform gauze in many abdominal sections, and had seen cases with rapid pulse from absorption. He believed that this was due to a larger percentage of iodoform in some samples of gauze. He had found carbolic gauze answer just as well.

Dr. HANDFIELD-JONES considered that much depended on whether the rupture was complete or incomplete. A list of 13 cases had recently been reported from Vienna, and they were all treated by packing with iodoform gauze; eight were complete, and the patients all died; the remaining five were incomplete, and all recovered. Lateral tears into the broad ligament generally recovered, whether treated by packing or by simple antiseptic douching; he had seen three cases of this kind and they all got well. He had had two cases of complete rupture; in one the child was found lying among the intestines; the rent had then so shrunk up that it was difficult to realise that the child had passed through it. In the other case the rent was through the fundus, and the peritoneal cavity was filled with meconium. Both cases were treated by abdominal section, but neither recovered.

Dr. HERMAN advocated gauze packing for most cases, but if the packing could not be passed right up to the top of the rent, through the vagina, then the uterus should be removed through the vagina. Dr. Spencer had given them a useful hint in advocating the passage of a large tube through the rent in order to evacuate the blood from the peritoneal cavity.

Dr. DRUMMOND ROBINSON had had three cases: two of these he packed, but one succumbed to shock; the other recovered and had since become pregnant again and had a normal confinement. In the third case the rupture was incomplete, extending into the left broad ligament; he had no gauze with him when he first saw the patient, and he left her, intending to pack the rent the next day. But at his next visit she was so much better that he did not use the gauze, and she recovered satisfactorily.

Dr. SPENCER, in the course of his reply said that he believed that the majority of the fatal cases were those of the incomplete type, i.e., into the broad ligament. Four of his eight fatal cases were of this kind. He did not approve of repacking every twelve hours under an anaesthetic; if gauze were used at all, it should be left in for three or even six days. He did not think aseptic gauze would be so good as iodoform gauze, for it would not be likely to remain sweet.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD FRIDAY, JANUARY 5TH, 1900.

Dr. J. B. BALL, the President, in the Chair.

Mr. PERCY DUNN, in a feeling and appreciative speech, proposed a vote of condolence and sympathy with the family of the late Sir James Paget, an honorary member of the Society. The proposal was seconded by Mr. SWINFORD EDWARDS and carried unanimously.

The SECRETARY read the report of the committee appointed at the ordinary meeting on December 1st, to organise a scheme for gratuitous attendance on distressed families of soldiers. The Committee reported that 203 members of the Society had written offering to co-operate in the scheme. Of these replies 44 were from consulting physicians and surgeons and from men practising in various special departments. The remaining 159 were from men in general practice.

Mr. L. A. BIDWELL then read his paper on

SURGICAL TREATMENT OF DILATED STOMACH.

The principal causes of dilated stomach were:—(1) cicatricial contraction of the pylorus, (2) malignant disease, (3) adhesions outside the pylorus, (4) gastroparesis, (5) spasm of pylorus, (6) floating kidney on the right side, (7) atony. Only the first three of these various conditions were discussed at length by the author. With regard to diagnosis, the following principal methods of examining the stomach was advocated: (1) inspection, (2) palpation, (3) percussion, (4) auscultation, (5) intubation, (6) artificial distension of the stomach with gas, (7) chemical examination of the stomach contents. The indications for operation on the dilated stomach were:—(1) pain usually localised to the pyloric region and felt in the back, (2) signs of dilatation of the stomach, (3) vomiting of solid food, (4) absence of free hydrochloric acid from the vomit, (5) some emaciation, (6) obstinate constipation. The surgical procedures which were undertaken for the relief of dilated stomach were, in malignant disease:—(1) pylorotomy, (2) gastroenterostomy. In non-malignant stenosis: (1) pyloroplasty, (2) gastroenterostomy, (3) Loretta's operation; (4) pylorotomy; (5) division of adhesions. And in neurotic cases: (1) lavage, (2) massage, (3) gastropexy, (4) an operation for diminishing the capacity of the stomach by folding in a portion of the redundant wall. The paper was illustrated by sixteen cases operated on by the author, and arranged in tabular form. Eleven were cases of malignant disease, five of these died within a fortnight, the remainder living some months. There were five cases of non-malignant stricture which were all cured by operation. Of the malignant cases seven were gastroenterostomies with three deaths, three were pylorotomies with one death, one was a case of pyloroplasty and proved fatal.

Remarks were made by the President, Messrs. Swinford Edwards, C. B. Keetley, McAdam Eccles, and Dr. R. Bevan. Mr. L. A. Bidwell briefly replied.

BRADFORD MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD DECEMBER 5TH, 1899.

The President, Mr. W. HORROCKS, F.R.C.S., in the Chair.

TUBERCULOSIS IN ITS RELATION TO PUBLIC HEALTH.

Dr. CROWLEY read a paper on the "Sanatorium Treatment of Phthisis." He laid stress on treatment in a sanatorium as distinguished from "fresh air" and other methods, in that it was a mental as well as a physical remedy; and he urged the importance of strict discipline in regulating and controlling every detail of the patient's life. Very satisfactory sanatoria could be made in most parts of the kingdom, provided that the air was pure and free from soot, the soil well drained, that the building was sheltered from the prevailing winds, and that there was a fair amount of sunshine. All cases were suitable for treatment, those in the early stages naturally yielding the most satisfactory results. A large proportion of cases were curable for the time being, the cure being maintained only if suitable habits of life were observed after the patient's return home. Finally, it was urged that the co-operation of the whole medical profession must be secured in order that sanatorium treatment should be a success.

Dr. ARNOLD EVANS read a paper on "Tuberculosis, its Prevalence and Prevention." The preventive measures recommended were:—(1) That persons suffering from phthisis be isolated in sanatoria, and their houses and furniture disinfected. That sputum and other discharges be not allowed to become dry, and so get diffused in the atmosphere. (2) That all dairies and cowsheds should be registered. That cows with indurated udders should be notified to the sanitary authority, and their milk not mixed with that of healthy cows. That the carcasses of slaughtered animals should be inspected by a competent person. That, till preventive measures were taken, all milk should be sterilised.

Dr. METCALFE urged the importance of early diagnosis, in order that treatment might be satisfactory.

Dr. MAJOR thought that public opinion was not yet ripe for compulsory notification, but suggested that some system of voluntary notification be adopted.

Dr. BELL said that the introduction of sanatoria was sure to be associated with a great deal of quackery. He threw doubt on the accuracy of statistics from institutions conducted for the profit of the superintendent. He advocated the compulsory notification of phthisis. He thought doctors would leave themselves nothing to do as general practitioners.

Dr. RABAGLIATI advocated the prevention of phthisis by inculcating into the minds of the public the importance of fresh air, exercise, and diet. He thought that public bodies might do much good by insisting that the living rooms of all new houses should have an adequate cubic space.

Dr. EURICH alluded to the prevalence of porcine tuberculosis, and remarked that the liver and tonsils were the organs chiefly affected.

Dr. P. LODGE congratulated the Society on its having two such representative papers of such far-reaching interest on the same occasion before them. He thought what was wanted was State sanatoria for the poor whose insanitary methods of living and state of knowledge particularly laid them at the mercy of this terrible scourge the tuberculous bacillus.

Drs. Goyder, S. Johnstone, and Horrocks also joined in the discussion, and Drs. Crowley and Evans replied.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, January 6th, 1900.

EXTRA UTERINE PREGNANCY.

Dr. LEFAGE, in lecturing on the diagnosis of the above, said that several cases of pregnancy, in reality uterine, had been taken to his knowledge for extra-uterine pregnancy. The diagnosis of the latter presented, however, difficulties varying with the period of the gestation at which the woman is examined and the intensity of the incidents produced. For the last ten years the diagnosis was rendered more easy by a more accurate knowledge of the symptoms. Yet it was frequently possible to confound the situation of the foetus in both cases. A woman is seven months pregnant since her last monthly period; she has lost blood several times and complained of suffering in the abdomen, pain not felt in previous pregnancies. Sometimes a doctor or a midwife called towards the third month of gestation have declared imprudently that abortion was imminent, and even that it had already taken place. Besides the patient had suffered some difficulty in emptying the bladder and the rectum. In a word, in questioning the woman the more or less classical type of ectopic pregnancy presents itself to the mind. It is thus that a strong road is being taken and will be persisted in if obstetrical examination reveals some anomaly in the form or in the situation of the uterus.

STRICTURE OF THE PYLORUS.

Prof. Chénieux has published an interesting case of stricture of the pylorus, cured by operation. The case was that of a young woman suffering from grave disturbance of the gastric functions. Appetite was lost, but no matter what she ate the stomach permitted considerable distension and afterwards emptied itself by vomiting. Food did not pass through the pylorus; milk, although more tolerated, was not completely digested. The patient consequently became emaciated and lost strength rapidly. Her medical attendant sent

her to Vichy, but with little benefit, and finally concluded that the case was one of stricture of the pylorus, and advised an operation.

The woman was operated upon by Prof. Chénieux, who, after laying bare the stomach made an incision perpendicular to the ring of the pylorus of an inch-and-a-half long. He drew together the two extremities of the incision which became thus transversal and parallel to the pyloric ring and then sutured with fine silk. No liquid flowed into the abdomen, which was closed without drainage.

The result was most satisfactory. The patient one month after the operation was able to well digest her food, while her strength and embonpoint returned with surprising rapidity.

ZONA.

An alcoholic solution 1-10, of picric acid is strongly recommended by Prof. Thiery for the treatment of zona. Painted on with a brush the alcohol evaporates very rapidly leaving behind a layer of protection. The inflammatory phenomena quickly disappear with this dressing and pain is suppressed. The application of picric acid in this manner also facilitates a definite cure.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, January 6th, 1900.

At the last meeting of the Society of Surgeons, Hr. Riese gave a contribution to the subject of

THE SURGERY OF THE SKULL.

He first showed a boy of ten who had been shot in the head, the bullet entering above the left orbit. The boy was brought in an hour after the accident, and at first had symptoms of general compression of the brain, with left-sided paralysis. The pressure symptoms gradually subsided, speech also returned, but the paralysis remained. The speaker believed that the internal capsule was injured.

A second case ran a similar course.

A third case was that of a girl of nineteen, who had the entrance opening below the right eye. There were no brain symptoms. The wound healed readily, but gradually headaches set in that reached such a high pitch that the girl, who had been discharged from hospital, was obliged to return. In the several Röntgen illuminations, the position of the bullet could only be seen from the side; according to these it appeared to be in the orbital fissure. The speaker then determined to search for the bullet, and began from the side, but it did not lie in the inferior orbital fissure, but in the superior, near the optic nerve and the motor oculi. It was removed, and the nerve, perhaps, bruised at the time but not torn; the ciliary ganglion was also touched, but was certainly not injured. In spite of this, separation of the retina took place. This became adherent again, but atrophy of the nerve had advanced.

In a fourth case a man had shot himself in the forehead whilst lying down. In the midst was a depression which, after healing of the wound, he treated by operation, removing some splinters and the bullet.

A weight fell on to the head of a child of four. A cephalæmatoma formed over both parietal bones, which as well as the unconsciousness increased. After five days the child ceased swallowing, left hemiplegia set in,

whilst twitchings took place on the right side. The symptoms of general compression gave way to local symptoms. The pulse was a good deal accelerated. The head was trephined both on the right and left side at the spot where the middle meningeal artery was generally sought for, and on the left side at the seat of fracture, a splinter of bone was found penetrating the brain. This was removed, whilst on the right side only a subdural and an epidural hæmatoma was reopened. The twitchings ceased after the operation, the paralysis continued until death, ten hours afterwards with increasing rapidity of pulse, until it became uncountable. Section showed a longitudinal fissure over the whole convexity of the skull down to the base, with extensive destruction of brain substance.

At the Medical Society Herr Mendel showed preparations from a case of

ACROMEGALY.

In November, 1895, the speaker showed the case and gave a history of it. In addition to the visible acromegaly there were hemianopsia bilateralis, struma, amenorrhœa, &c. There were violent headaches and vomiting, and in the free intervals between polyphagia and polydipsia. The patient died in October, 1899. Section confirmed the diagnosis previously given of the disease of the hypophysis. There was a tumour proceeding from the hypophysis which had destroyed it, and which had grown forwards and backwards on the dorsal aspect, and had reached the size of a walnut. Microscopically, it proved to be a myxosarcoma. Besides this there was a goitre the size of two fists with colloid contents, a persisting thymus (five ctm. in length), an enlarged spleen (twenty ctm. in length), small cysts in the ovaries, and mammae of enormous size. As to whether the other changes had any connection with the disease of the hypophysis that led to the acromegaly, there was nothing to show. Possibly the case showed that acromegaly was a general disease that implicated several organs that were functionally related to one another. Organo therapeutics put into use (fresh hypophysis substance from the slaughter-house) in this, as in other cases, left them in the lurch.

GASTRO-INTESTINAL DISINFECTION, BACTERIOLOGICALLY CONSIDERED.

At the same meeting Hr. Schütz, Wiesbaden, read a paper on this subject. The estimation of the value of the gastric juice in the digestion and absorption of material from the small intestine had receded, but the antiseptic power of a two per cent. solution of hydrochloric acid was uncontested. It was not improbable that this power was chiefly exercised in the stomach. It had been shown that there was no relation between decomposition in the intestine and gastric juice. The writer had endeavoured to study the flora of the intestine, and to compare them with those growing when hydrochloric acid was withheld. He had to find a species of bacterium which passed into the duodenum of the dog direct (without contact with gastric juice) and it did not appear in the fæces, therefore died in the intestine; further that the bacillus passed through the stomach under normal conditions, and that therefore H.Cl. was not an unsurmountable obstacle. Only one bacterium answered to these conditions, and that was the cholera vibrio Metchnikoff. The experiments were made on the dog as being equally omnivorous with the

human subject. After feeding with the vibrio and killing the animal, the faeces were then examined by cultivation. After describing the mode of preparation of the vibrios the speaker went on to say that the infective material was given in large quantities—in three young dogs five to fifteen milliards in four to eight weeks. After preliminary experiments which showed that under normal conditions the vibrio did not pass away in the stools, he proceeded with his experiments, and passed the infective material direct into the duodenum. Even without any influence from HCl no vibrios passed through the intestinal canal whatever quantity might be given. But if purgatives were given simultaneously (calomel, castor oil), then the stools contained the vibrios, for twelve hours after they had been given. As regarded post-mortem appearances, the small intestine was highly inflamed, as after cholera infection. The vibrios, even in large quantities disappeared before reaching the large intestine. The experiments showed that the vibrio passed through the stomach capable of development, even when given along with food that furthered the secretion of gastric juice. There was, therefore, a highly energetic power of disinfection in the upper parts of the bowel that indicated an antiseptic property in the bile. The speaker finally sought to explain how disinfection in the intestine acted on the bacteria of decomposition, and pointed out that calomel did not remove the germs, but that they continued to appear for twelve hours after administration, while in the other animals they had disappeared from the intestine within two or three hours after their last administration.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, January 6th, 1900.

TUBERCLE IN BUTTER AND MILK.

WISSENFELD, of Bonn, has confirmed many of the suspicious and bacterial examinations made in the laboratories of this city. Twenty examinations of milk at dairies and twelve at the farms in the Rhineland have resulted in the discovery of the genuine tuberculous bacillus. His experiments were carried out in the usual manner on guinea-pigs with control animals.

The deposits from butter and milk after passing through the centrifugal machine were injected into animals weighing 300 to 500 grammes in doses ranging from 0.5 c.c. to 5.0 c.c. Of the thirty-two tests twenty-two gave no reaction of tuberculosis in the animal organism. The remaining ten had a variety of phenomena. One test of milk from the Rhine province was undoubtedly tuberculous; while two others of butter from the farms, and having a large sale in the town as fresh, were also tuberculous. The remaining cases were well defined pseudo-tuberculosis.

Wissenfeld has gone further, and demonstrates that our so-called artificial nutrients from these products are also infected with the diseased germs and dangerous for consumption, particularly by invalids. He has tested "Nutrose," "Eucasin," "Kalkcasein," "Plasmon,"—"Siebold's Milcheiweiss"—and found large quantities of the bacilli which were evidently active from the confirmatory experiments carried out on animals.

STRUMECTOMY.

At the "Gesellschaft der Aerzte" Schrötter exhibited two cases which he had operated on and which had been before the meeting when one was diagnosed as a misplaced thyroid the other as a foreign body in the bronchi.

The displaced thyroid had descended so far as to press on the trachea and produce stercus with painful breathing. Strumectomy was performed under local anaesthesia. Ten cubic centimetres of a 1 per cent. solution of cocaine was applied to the tumour and it was removed without trouble. Immediately after the operation the patient was able to breathe freely without any cough.

The lead pencil which had lain wedged four months was removed from the bronchi by means of a long tube and forceps combined.

Weinlechner remarked that the removal of the thyroid gland was best effected by means of local anaesthesia as it abolished the coughing usually troublesome during the operation. He always applied it himself in the manner recommended by Mikulicz, which is by a compress fastened with an elastic band round the neck.

The Operating Theatres.

WEST LONDON HOSPITAL.

PATELLAR SINUS LEADING TO PRÆ-PATELLAR ABSCESS.

—MR. SWINFORD EDWARDS operated on a little boy, *æt.* 12, who had been admitted for abscess situated over the ligamentum patellæ. The articulation had within the past day or two exhibited some symptoms of inflammation so that it was feared the abscess might have burst into the joint. On this point Mr. Edwards remarked that as the boy's temperature was not very high being only 99, and as there was not much heat or redness about the joint, nor much distension, he was inclined to think that the pus had not found its way into the joint, but that the articulation was partly distended with some effusion owing to the juxtaposition of the abscess cavity. Such proved to be the case after the abscess had been exposed and thoroughly scraped of the granulation tissue lining it. From the upper part of the abscess cavity just below the patella a sinus was discovered through which a probe passed on to bare bone; thinking that this was on the articular surface of the patella Mr. Edwards opened the knee-joint on the outer side when about a tablespoonful of synovial fluid escaped, this was more watery in consistence than normal synovial fluid should be. On examining the articular surface it was found there was no erosion anywhere. With the patella now grasped between the finger and thumb, the former being in the joint and the latter outside it, it was found that the probe entered an abscess cavity in the interior of the patella which cavity had two outlets, one the sinus above referred to which entered the bone on its lower and inner border, the other on its lower and outer border; they both communicated with the exposed abscess cavity. The bony cavity was now thoroughly scraped out with a Volkmann's spoon, and a drainage tube inserted which was brought out through a separate incision on the outer side of the joint, the joint itself being drained through the original incision. Mr. Edwards remarked on the rarity of abscess in the

patella itself. Had he not believed the articular surface of the patella to be involved he would not have opened the joint; having done so, two courses he said were open to him, the one to sew up again the capsule immediately after opening it and after having washed it out with a weak solution of sublimate to thus shut it off again from the abscess cavity, the second which was to pursue the course he had adopted, namely, of draining the joint.

It is interesting to note that no ill-effects have followed this exposure of the joint, and the drainage tube was removed from the articulation at the end of forty-eight hours; the discharge escaping from the abscess cavity is diminishing daily in quantity, and is now, a week after operation, very small.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JANUARY 10, 1900.

LOCAL AUTHORITIES AND ADULTERATION.

DESPITE the fact that of late years vast changes for the better have come over the spirit of vestrydom, there nevertheless remains, on the other hand, ample room for improvement. The importance of the branch of local government concerned is shown by the vast sums of money they are called upon to disburse with regard to roads, sewers, lighting, scavenging, sanitary and other administrative matters. It is vital to the welfare of the community, therefore, that they elect honourable and enlightened men to manage their local government, and it is only when the public interest is sufficiently aroused to make parochial elections thoroughly earnest and representative that irreproachable candidates are likely to be returned. At present there is no need to go outside the metropolis for examples of all kinds of sheer, crass maladministration and questionable expenditure. Money is spent freely in certain directions, while it is grudged upon things that are absolutely necessary from a public health point of view. The policy of the Local Government Board has always

been to interfere as little as possible with local administration. A time comes, however, in the history of many vestries and other local governing bodies when the central controlling board is compelled to interfere, and to insist upon the fulfilment of statutory duties. During the past year, Mr. Chaplin has had in this way to assert his supreme authority, both in London and in the provinces. It is not an altogether unreasonable surmise, judging from past experiences, that his interference may be called upon still further in the case of certain Vestries that have delayed and avoided necessary sanitary reforms in an arbitrary and unfavourable manner. In one instance, at least, an artful arrangement has come to light, whereby the reports of the Medical Officer of Health were strangled in their birth by a sub-health Committee, so that by the action of a small clique not only the Health Committee but also the Vestry were kept in ignorance of the representations of their Medical Officer as to nuisances and other matters vital to the health of the district. Unfortunately, instances in which a zealous and efficient Medical Officer of Health finds himself at variance with his vestry are not uncommon, and it is to be hoped that some scheme may be devised to prevent the gagging of such an official by methods of the kind above mentioned. Among the multifarious duties committed to the care of the vestries is that of the administration of the Food and Drugs Act, a function of direct interest to every ratepayer. As a rule, however, the matter is dealt with in such a slipshod way that the evil deeds of the adulterator are allowed practically to go unchecked. The year's work of an average vestry in this direction comprises a few prosecutions of milk-sellers, and the examination of a certain small number of samples of foods and drugs taken by the Vestry officials. The utter inadequacy of this test either to ascertain or to prevent adulteration must be apparent when it is remembered in what a host of ways this sort of fraud is perpetrated. If an inspector were to walk into a single grocer's shop and begin to take samples of stuffs known to be commonly adulterated he would come away with enough to employ the time of the official analyst and his staff for a month. Under the present lax system, however, out of the many millions of shops in the United Kingdom liable to the control of the Food and Drugs Act the majority escape even a superficial test. Not many years ago a little attention to the publicans revealed a widespread and scandalous adulteration of beer. Why has that investigation not been repeated? We venture to assert that a preconcerted seizure of samples of some common article of food, say pepper, throughout any given district would result in some startling revelations from the analytical laboratories. The reason of this apathy on the part of vestrymen as to the purity of foodstuffs is not far to seek. As a rule many of them belong to the tradesmen class, and they are not unnaturally averse

to interference with trade matters. Then, again, the Medical Officer of Health and his inspectors have already quite enough on their hands in other directions. As to that anomaly, the half-time Medical Officer of Health, no one could for a moment seriously expect him to look after such details as the purity of food and drugs. Yet various wealthy and crowded London parishes, such as St. Saviour's, Southwark, Bermondsey, and Holborn, do not think it necessary to employ more than a portion of the energies of one man as their Medical Officer of Health. It is a question whether, under existing circumstances, the administration of the Act should not be handed over to a central authority, such as the London County Council. Then, again, the Public Analyst service needs thorough revision. Pluralism, save under the most exceptional circumstances, should be sternly discountenanced by the Local Government Board, and payment should be by fixed salary. As things go there is no possibility of a public analyst discharging the duties of that post to several large and separate districts, that is to say, if the Acts are to be efficiently administered therein. It is to be hoped that before the close of the year upon which we have recently entered some efficient steps will have been taken by the Local Government Board, beginning with the headquarters at Somerset House, to secure the purity of the food of the people by the agency of existing laws.

THE DUBLIN HOLOCAUST.

INASMUCH as the mortality rate of Dublin City, as reported by the Medical Officer of Health, has reached the awful proportion of 46·0 per 1,000 of the population, while the rate for English and Scotch cities under similar circumstances of season and climate reaches only 18 or 19, no one can be considered too critical who speaks out respecting the ineptitude of the Dublin City Corporation, and of the citizens themselves. We fully anticipate the reasons which may be given by the Corporation for this terrible condition of Dublin sanitation, and, for the present, we admit their force. We allow that there are prevalent temporary epidemics which have increased the mortality roll, and we also admit that the miserable weather which has obtained in Dublin has brought in an increased harvest of deaths from pulmonary diseases, but we want to know why these adverse conditions should do more harm in Dublin than in other similarly situated districts? The answer given to this question is that in Dublin the population is ten times more receptive of infective disease—ten times more likely to die under such disease—and ten times more likely to succumb to respiratory disease than the denizens of other cities, and we are constrained to confess the validity of this defence. The simple fact is that the lower classes in Dublin are the easiest possible prey for disease in any form. Many of them have been nurtured and brought up in squalor and privation without a decent bed to lie on, or protective (not to say decent) clothes to cover

their nakedness, or moderately fair air to breathe, and, in their budding years of discretion they are gradually, but inevitably, broken in to the constant use of the vilest whiskey and equally atrocious tobacco. Seldom, from their infancy, do such receive an abundant and nutritious meal, or, until they are past puberty, rejoice in the ostentatious comfort of a warm suit of clothes. Is it wonderful that such items of a population die like murrained sheep when attacked by any of the assaults of disease which other communities experience, or that the mortality rate runs upon such occasions to 46·0 per 1,000 of the population? This is a matter which calls for no further investigation save as to the details of the remedy which should be applied. The "tenement house" has been marked down by two Commissions of inquiry and by the common consent of every critic as the *fons et origo mali*. These habitations of the Dublin poor are, in a majority of cases, the dilapidated wrecks of the mansions of the nobility and gentry, and of their aristocratic dependents, who kept state and squandered their patrimonies in Dublin in the time of the Georges, and these mansions, for the past hundred years, since the Union, have been abandoned and crumbling to ruin. The remaining shells of the houses are bought for a nominal sum by speculators and let out to the poor at a profit before which the income of the mines of Golconda or the dividend on Guinness's brewery are as nothing. It is possible to buy a magnificent mansion in some of these long ago fashionable streets for £30 or £50—a mansion with ceiling and fittings which must have cost thousands, and it is sworn before one of the Commissions that such a house, purchased for £30 brought in a steady income of about £250 a year. This monstrous profit is got by cutting up the palatial reception rooms into separate tenements by erecting lath and plaster partitions and often by shoulder-high divisions, which enable the owner to take rent from half a dozen tenants for one room. Thus, as many as seventy persons are sometimes huddled together in one house. To these sub-divisions there is, of course, no fireplace, nor any ventilation except such as is derived from the use of one or two windows (which are seldom opened) for the whole room, the cubic space of each tenement is, usually, whatever the owner likes to make it, and the only *cloaca* for the whole establishment is in the back yard down four flights of stairs from the top rooms. These tenement houses are frequently in possession of retired policemen or other people who have no capital, and are driven to wring the uttermost penny out of their investment by setting themselves against expenditure on improvements of any sort, or else the owners are speculators on the large scale, who are themselves members either of the Corporation or of the Sanitary Authorities, a position which enables them to oppose effective resistance to every suggestion of reform. Sir Charles Cameron, since his appointment as Superintendent Medical Officer of Health, has done as much as the very limited

supply of money which the Corporation allows, and the opposition referred to permits. He might institute a strict house-to-house inspection and might serve notice on the owners that he would, forthwith, close the premises if the necessary improvements were not effected but, if the medical officer dared to do this against the influential tenement-farmers he would still be face to face with the problem as to what would become of the multitude of poor tenants thus dispossessed for whom no other accommodation at present exists in the city. They would not thank him for interfering as, in most instances, they are insensible to the delights of cleanliness or decent comfort, and are only able to pay rent to the amount of 1s. to 2s. per week from which no speculator could make a profit if he had to provide decent accommodation. The Q. E. D. of all this statement of fact is that the mortality of Dublin city can never be materially reduced, nor can its lower classes be ever made clean and self-respecting until the tenement traffic is extinguished by providing, at the public expense, tolerable habitations for the poor. To do this would, in the long run, cost the citizens very little. Several sites can be had for almost nothing, their areas having been cleared by the tumbling down of the houses thereon—the buildings might be quite cheap though in all respects sanitary and suitable if only the architects and engineers could be deterred from decorating them in the æsthetic style, and, on these terms, the accruing rents would at least pay interest, sinking fund, and repairs, leaving the property clear to the Corporation at the lapse of the sinking fund. We have presented the subject in this form, not at all by way of apology for the crass incapacity of the Dublin Corporation, but to excite the citizens, who are almost as much to blame, to take the Corporation by the throat and insist on the immediate initiation of remedial measures. We are fully impressed with the belief that squalor, savage ignorance, poverty, and depravity cannot be cured by any method of administration, however enthusiastic, within a measurable period, but it is now, within our own knowledge, forty years, and we don't know how many more, since the bestiality of the life conditions of the very poor in Dublin has been as obvious, and, at this moment, the Corporators appear to be as indifferent to the deaths of the poor or the miseries of, and degradation of, their lives as ever they were. They can traffic with contractors for municipal work, or pass bombastic political resolutions; they can afford to pay out £91,000 for the building of villas for artisans (who are all voters), and £260,000 for an electric scheme, but they will not give one sixpence to the regeneration of the sick and dying poor population. Why should they? "Rattle their bones over the stones, they are only paupers whom nobody owns."

MORITURUS.

WELCOME has smiled too soon upon the twentieth century, and we have still another year before the

parting guest has flown. It rather seems as if we should have been glad if it were past if this would leave us freer to act as reason prompts in effecting certain desirable changes. Bad habits have been growing up which no one has cared to correct. In our article on the Past Century we referred to the men whose influence was paramount in matters of interest to the profession, when the nineteenth was young; and we drew attention to the spirit, that stimulated the best men to work as they did, and make the great advances that we can now look back upon with admiration. Of late, however, things have changed. Money has been the object which even science has had in view. Science like religion used not to bow to wealth or be patronised by it; but of late, in the relations between the public and the profession, those feelings which had influence in making the life of a good doctor not unenviable, have been passing away; and the services he rendered have been thought no different from those of an ordinary tradesman. The great body of the profession is beginning to suffer, and now questions are arising as to what course men will take collectively and individually in righting the abuses that their own indifference and, we fear, their self-interest have brought about. In the Church there has been trouble brewing for some time; and evil tendencies have been shown to pander to the weaknesses of Society. To have seen the Royal College of Physicians scheming to obtain control of the profession by extinguishing the Society of Apothecaries, and dominating the new University, through which alone the title of Doctor could be obtained in this great city, was not pleasant for those who took a very different view of how such matters should be conducted. It was nobody's business to oppose, and things looked as if they were going from bad to worse. Some men there were who had common sense, and were not so little Christian in spirit as to let injustice prevail. The College of Physicians has righted itself; and we hope that now the few months of the century that is dying out will be spent in some general call for an auditing of accounts, and in some movement to reform those abuses which under the guise of charity have been creeping in, to aid pretentious specialism to advertise itself, and take advantage of credulity and ignorance. To what extent the general Press has lent itself in advertising and in other ways we will reserve for consideration. It rests with the great body of the profession to correct these abuses, for they can do so if they please. If they do not do so they will suffer.

Notes on Current Topics.

The Field Hospitals for the Transvaal.

THE hospital equipment provided by the generosity of Lord Iveagh is expected to leave Southampton about the 20th inst. It will consist of 62 men, besides the surgeons and dressers, 20 waggons and

carts, drawn by 80 mules. There will also be 8 tortoise tents capable of accommodating the 100 wounded whom the hospital is designed to succour, besides 20 living tents for the staff. Female nurses will not accompany it. The whole will be under the administration of Sir William Thomson, of Dublin, as chief surgeon, Mr. George Stoker, of London, Mr. Friel, of Waterford, and a fourth civil surgeon who has not yet been named, and there will be 6 dressers, qualified men, who have been already selected. Major Mould, R.A.M.C., who has seen considerable service in the East, will accompany the expedition as military organiser, and Major Courtenay as financial commissioner acting for Lord Iveagh. Of these gentlemen it is scarcely necessary to say much. Sir William Thomson is the well-known Surgeon to the Richmond Hospital, Dublin, Senator of the Royal University of Ireland, ex-President of the Irish College of Surgeons, and Direct Representative for Ireland in the General Medical Council. Mr. George Stoker brings to the expedition invaluable experience in medico-military matters as one of the Stafford House Surgeons, and Surgeon in the Imperial Ottoman Army, and he is well-known to the profession as the exponent of the Oxygen method of treatment, and as an authority on throat diseases. Mr. Friel was a surgical travelling prizeman of the University of Dublin, and served with honour the House Surgeoncy of the Richmond Hospital. This hospital will be charged with duty on the line of communications, and will not be employed at the base hospitals.

The Post of Registrar-General.

THE Registrar-General has hitherto been regarded as a purely administrative officer in charge of an important department having for function to secure a permanent register of births, marriages, and deaths. The statistics, originally collected for purely social purposes, have since been made to serve other, perhaps much more important, purposes; indeed, it would be difficult to over-rate the value to the community of the deductions and conclusions drawn from these figures bearing on the incidence of disease and death. To the late Dr. Farr in his capacity of superintendent of statistics belongs the credit of having directed attention to the far-reaching importance of these statistics, especially in the direction of preventive medicine. Apart from the mere record of facts these statistics require for their co-ordination and analysis a man possessed of medical knowledge, who moreover is cognisant of the requirements of those to whom these statistics will appeal. Since Dr. Farr initiated his method of dealing with the records the importance of the labours of the superintendent of statistics has gone on increasing until they quite outshadow those on the purely administrative side. The Registrar-General collects the figures, but it is the privilege of the superintendent of statistics to classify them and clothe them with the scientific interest which they possess when presented to the public in the annual reports. The approaching retirement of Sir Brydges Henniker, the present Registrar-

General, under the limit of age, affords a favourable opportunity for urging the desirability of selecting a medical man to fill that responsible post, and if this point be conceded the present superintendent of statistics would obviously have a preferential claim. The ever-increasing extent to which these statistics, in their medical aspects, are made use of by the various health authorities justify the view that the lapsus which at present mars the accuracy of some of the returns would stand a better chance of being remedied under a medical registrar-general than under the guidance of a lay administrator, no matter how able. This feeling found expression in many quarters on the last occasion of the post falling vacant, but Dr. Farr's advanced age and uncertain health virtually excluded him from the succession. As no such objection presents itself now it may be hoped that this aspect of the question will be borne in mind in choosing a successor to the able administrator who is shortly to retire.

Funeral of Sir James Paget.

THE funeral service over the body of Sir James Paget took place at Westminster Abbey on Friday last with a pomp and ceremony worthy of the illustrious dead, whose memory a large number of friends and admirers had assembled to honour. The coffin was covered with wreaths and flowers sent by the Prince and Princess of Wales, the Baroness Burdett-Coutts, the staff of St. Bartholomew's Hospital, and others. Her Majesty was represented by Captain N. C. Phillips and Dr. Barlow, the former bearing a wreath of roses inscribed "A token of respect and esteem.—Victoria, R.I." The procession was met at the gate of the Abbey by the clergy and choir, and the opening sentences of the Burial Service were chanted to Croft's setting as it advanced into the choir. The lesson was read by Canon Duckworth, after which the choir sang Sir H. Oakeley's beautiful anthem, "Comes at times a stillness as of even." After the benediction, the coffin was carried out of the Abbey by the west aisle and conveyed to Finchley where the interment took place.

Professor Schenk in Disgrace.

THE worldwide notoriety which Professor Schenk attained on the publication of his ingenious theory of the determination of sex, based, alas! on too slender a foundation of research and observation, appears to have given umbrage to his colleagues in the University of Vienna. The work in question was formally censured by the Disciplinary Council of the College of Professors, and a petition was addressed to the Minister of Public Instruction asking that the author might be removed from his chair and deposed from the management of the Embryological Institute. The petition has been so far acceded to that the professor has been accorded unlimited leave of absence, with an intimation that he is at liberty to apply for a pension. In view of the fact that Professor Schenk has been at the head of the Institute for something like twenty-six years, the general

impression, at any rate, in the lay press, seems to be that he has been hardly dealt with, but the critics overlook the special obligations and responsibilities attaching to the honoured position of professor, and it is quite unfair to place Professor Schenk on a footing with Koch, who was only partially responsible for the premature publication of his researches on tuberculin, and whose valuable contributions to science in many directions place him on a pedestal apart. The worst punishment for the unfortunate professor is the consciousness that he will go down to posterity as the originator of what Lowell called an "exploded idea." This is the fate which awaits those who allow their thirst for fame to outrun their scientific discretion.

Severe Type of Influenza in Edinburgh.

OUR "Own Correspondent" informs us that Edinburgh is at present in the throes of a severe type of influenza, especially attacking the lungs and the temperature mechanism. We regret that one of the most recent victims was a very promising member of the profession, Dr. George Elder, F.R.C.P.E. Dr. Elder, who was only thirty years of age, had a most distinguished University career, and at the time of his death was a clinical tutor at the Royal Infirmary and an assistant physician to Leith Hospital. He was also joint author along with Dr. J. E. Fowler of a text-book on children's diseases. His early decease cuts short a career of great promise, and is a source of deep regret to his many friends.

Post-Graduate Tuition at the Cape.

THE war in South Africa has so dislocated affairs in the Colony that the *South African Medical Journal*, many of whose subscribers reside in the Transvaal, Orange Free State, and Natal, has announced with its December issue that it will cease to appear for six months. We have, however, in the copy before us read with much interest the proposed scheme by Dr. Darley-Hartley, of Cape Town, for establishing a Post-Graduate centre in the Colony. Dr. Hartley, in speaking in glowing terms of the West London Post-Graduate College, says that "it affords especially valuable guidance," for his scheme, inasmuch as it carries on its work under conditions fairly approximate to those that exist in Cape Town. It may be pointed out that Dr. Darley-Hartley was a year ago a member of the West London Post-Graduate College, and that he still maintains his interest in the hospital and its work by being a subscribing member of the West London Medico-Chirurgical Society. His grasp of the requirements of post-graduate teaching is well shown by the thoroughly worked-out scheme which he has elaborated for organisation in Cape Town; that is really the essence of the whole matter—namely organisation. Unless this be such as to touch the pulse of those requiring post-graduate aid, no success is likely to be attained. Nor is it an altogether easy matter to supply post-graduates with exactly what they want. The first *sine qua non* is undoubtedly a large general hospital, with its various fully equipped departments

Then there is the teaching staff, who require to possess, some at least, capacity for this purpose. According to Dr. Hartley, the provision of lecturers and material would probably be the most difficult part of the enterprise in Cape Town. However, these are details which no doubt will be overcome satisfactorily in the course of time, and meanwhile we can only express our hearty wishes for the success of the movement which Dr. Darley-Hartley has inaugurated.

The Bakers Again.

THE journeymen bakers are in a chronic state of revolt, and the community at this present moment is threatened with a strike on a large scale. In London alone it is estimated that some 14,000 men will thus withdraw from that necessary occupation. Their chief demand appears to be for a shorter week than 70 hours, a request that seems reasonable enough on general grounds, to say nothing of the facts that the trade is unhealthy and the wages poor. Some years ago a great outcry was raised against the cellar bakeries and the conditions under which bread was made in the smaller bakehouses. Government has since made it illegal to start any new bakehouse underground. Clearly, inasmuch as a vast number of such places are already in existence, the fresh legislation simply touches the fringe of the evil. The old underground bakehouses, with all their noisome and insanitary surroundings, remain for the most part untouched. The vestries refuse to enforce a decent sanitary standard, because they are loth to interfere with tradesmen in their districts. The journeymen bakers are apparently not well enough organised to insist upon proper housing and decent wages. The public seem apathetic as to whence their bread comes and under what conditions it is prepared. Some years ago, at the Bristol meeting of the British Medical Association, a paper was read showing that baking did not necessarily destroy harmful germs contained in the dough. Those experiments have a most important bearing on a possible means of distribution of such diseases as cholera, summer diarrhoea, plague, and enteric fever, but so far as we know they still await confirmation by some public health authority. The only hope of efficient control of bakehouses seems to lie in the direction of a central authority. In London the powers should be vested in the County Council, to be carried out by a special staff of skilled inspectors. In many ways machine-made bread is more wholesome than that made by hand, at any rate, its methods of preparation are infinitely more cleanly.

The Lesson of Vaccination at Hull.

THE town of Hull has had to pay dearly for its lesson in vaccination. The chairman of the Sanitary Committee of the Corporation announced last week at a meeting that the cost of vaccinating and re-vaccinating the townspeople had amounted in fees to the medical men to £7,500 during the past twelve months. The rates, therefore, will be bur-

dened to this extent, and nothing could be more calculated than the raising of the rates to bring home to the community the folly of refusing to abide by the teaching of vaccination. The returns show that 80,000 persons were vaccinated or re-vaccinated, of whom about 20,000 would be private patients of the medical practitioners of the town. The townspeople, however, may take some consolation from the fact that they are not likely for some time to suffer from another epidemic of small-pox. They have now wisely protected themselves, and if in the future they bear in mind the lesson in vaccination which they have just been taught, a visitation such as that which brought death, disease, and loss of trade in its train will not be their lot again.

French Doctors Painted by French Authors.

SINCE the days of Molière, French authors have shown scant sympathy with the practitioners of medicine, but as a general rule their gibes have been directed against the mysticism and alleged ignorance of the followers of *Æsculapius*, in fact, the attacks were satirical rather than critical. During the last few years the attitude of authors has undergone a change for the worse in that they appear to take a wicked pleasure in holding the doctor up to obloquy and contempt by more or less precise allegations of venality and actual professional misconduct. The ignoble author of "*Le Mal Necessaire*" paints the clever but unscrupulous surgeon who operates for a fee without the slightest regard to the necessities of the case and the interests of his patient, and winds up by representing him as performing total hysterectomy on a young lady who was pregnant as the result of the advantage he had taken of her temporary unconsciousness some months previously. Léon Daudet, the unworthy offspring of a great sire, in the *Morticoles* wove a dreary but highly-coloured picture of a hypothetical world in which doctors were all powerful, and he paints them as capable of every crime and of every abuse. Still more recently Zola in his "*Fécondité*," with his peculiar facility for unearthing the hideous in life, introduces us to the abortionist doctor and the unscrupulous surgeon, nicknamed "the universal steriliser," in short, he leaves a very disagreeable impression on one's mind of medical practice in Paris, if not in France as a whole. If these authors and others are to be believed, morality, and even mere honesty, are conspicuous by their absence among French practitioners, even in the highest ranks of the profession. Dichotomy, the practice of sharing fees extorted from patients, is reputed to be quasi-universal, and any idea of a responsibility towards the patient is everywhere scouted. We decline to accept the pictures as true to nature, for the profession in France could not continue to exist were its morality at as low an ebb as we are invited to believe. At the same time there undoubtedly exists scope for reform in that there is no body corresponding to our General Medical Council possessing the power of weeding out the unworthy. The French doctor may advertise in the most unblushing manner without let or hindrance,

and provided he keeps clear of the criminal law he is amenable to no disciplinary jurisdiction. Even after conviction apparently he is free, as soon as he has purged his offence, to recommence practice so that the ranks of the profession inevitably comprise many black sheep. The pity is that French writers select these black sheep for their heroes or villains, as the case may be, to the detriment of the reputation of the profession as a whole.

The Lutterworth Guardians and Vaccination.

THE Lutterworth Guardians have been fighting the Local Government Board for a year upon the question of the control of their vaccination officer. The Board refused to ratify the last appointment of such officer by the Guardians because it embodied illegal limitations in his duties, and this took place a year ago. The Guardians a week or two ago were, therefore, requested to make an appointment forthwith. This order has now been carried out, the officer appointed having simply to fulfil the requirements of the Act without any restrictions. But the Guardians did not take the "snubbing" of the Local Government Board kindly. One sagacious member protested strongly against being, as he described it, "over-ridden by Mr. Chaplin." But it was pointed out to him that unless they obeyed the instructions of the Board their fate would be similar to that of their colleagues at Leicester. Thus the example made of the Leicester "martyrs" is proving eminently useful to the country.

Sensational Discoveries.

NOR so many years ago the main source of wonderful occurrences and discoveries was the United States, but since the realisation of the telephone, the phonograph, and sundry other exceedingly curious but very authentic marvels, we have learned to take American discoveries more seriously. The mantle of Elijah now seems to have fallen on French shoulders, and every year brings its array of wonderful discoveries, by no means always duly authenticated, from over the channel. Poor Brown-Séquard gave the scoffers a chance when he promulgated his new elixir *v.tæ*, but though this has made the fortunes of pharmacists it has failed to conquer a place of honour in the domain of what we may call vital therapeutics. Then, or possibly earlier, Pasteur discovered a cure for hydrophobia which, to put it mildly, is still on its trial but, if not all that is claimed for it, this discovery has a sound basis of scientific research which may even yet secure its triumph. The most sensational discoveries, however, have been reserved for the last few months. We have been treated to an announcement of the discovery of a body which should be capable of furnishing oxygen in profusion without trouble and at trifling expense. It turns out that the body in question is a salt of vanadium, but though interesting from a physical point of view, its practical utility in medicine has yet to be shown. Proceeding, *crescendo*, the great Dr. Metschnikoff, whose epoch-marking researches in bacteriology erstwhile startled the

scientific world, puts forward a claim to have discovered a serum capable of delaying, if not preventing, the sclerotic changes which characterise senile decay, in other words, of staying the activity of the macrophages, the variety of phagocyte which determines these changes in our tissues and organs as soon as the vitality of the cells begins to fail, by reinforcing the latter. We gather that he does not promise terrestrial immortality, but merely death from genuine old age, and not from some intercurrent disorder of the sclerotic kind. To close the list there is the discovery of a serum—the ubiquitous serum—obtained from alcoholised animals, the injection whereof is guaranteed to excite in the subject of the experiment an invincible repugnance for all alcoholic beverages. A special committee has been appointed by the French Academy of Medicine to investigate the subject, whose report we shall await with sceptical interest.

Unwholesome Condensed Milk Again.

THE urgent necessity for strict control of the supply of condensed milk has once again been shown by the successful prosecution of a city merchant who was found in possession of 156 cases of putrid condensed milk. The unsatisfactory feature of these prosecutions is that the guilty parties are let off with a pecuniary fine instead of being sent to prison. A very trifling offence against property is promptly punished by a term of imprisonment, whereas this very grave and wicked fraud is thought to be adequately punished by a mere fine, a fine, moreover, nothing like large enough to act as a deterrent in view of the immense profits attending such sales. By and bye, perhaps, our legislators will learn to treat the sale of injurious products for food as a crime akin to arson in that the delinquents deliberately set free destructive forces capable of working immeasurable harm.

The Drugging of Beer.

OF all popular myths there is none more firmly rooted in the mind of the public than that of the drugging of drinks, whereby the would-be criminal of various grades is enabled to rob his victim of the power of resistance. The latest sensation of the kind, unearthed by the *Westminster Gazette*, relates how thieves invite likely persons into a public house, and drop into their beer some chloral crystals, a drug which sends them "to sleep almost at once." The journal quotes some remarks made by Sir Henry Littlejohn, as witness in a recent case to the following effect; "He was sorry to say that chloral was too easily obtained by the vulgar. It was a perfect disgrace to society that so much facility existed for the possession of this most potent drug. Women and men, boys and girls, could get possession of it without let or hindrance." So far as it goes that expresses advanced medical views upon the subject. The practically unrestricted sale of chloral and of other potent drugs is nothing short of a scandal that demands the earnest and constant attention both of the General Medical Council and of the legislature. It

should be noted, however, that Sir Henry does not commit himself in the above quoted passage to any opinion as to whether criminals are in the habit of administering chloral in beer. There are, as a matter of fact, many reasons against such a "hocussing." In the first place, chloral has a most nauseous taste, which would not be disguised by the flavour of any malt liquor. Secondly, it would take a large dose—say, half a drachm to a drachm—to induce sleep within a period that may be estimated at about half-an-hour. That effect, moreover, would be inconstant. If a man were already intoxicated, no doubt the chloralised beer might escape detection, and hasten the advent of narcosis. Meanwhile, the drugging theory had better be left to its legitimate field in the novel and on the stage.

The Pathos of Medical Practice.

THERE is undoubtedly a pathetic side to the incident of a medical man attending a patient, when the former is much more in need of medical attendance than the person who has sought his aid. But the pathos is greatly increased when at the bedside of a patient the practitioner suddenly falls dead from some long standing malady. An incident of this kind occurred last week. Dr. Gimson, of Fitzroy Square, was summoned to a patient in Wigmore Street. After a short conversation with his patient, Dr. Gimson sat down in a chair, and in a few moments he was found to be insensible. At the inquiry which took place before the coroner, evidence was given of a post-mortem examination which had been made, and death was found to have been caused by the rupture of an aneurysm of the aorta. That is to say that probably for many months this practitioner had proceeded about the arduous duties of his practice, administering relief to suffering humanity, while suffering himself from a malady which required careful treatment and rest.

Hospital Subscriptions and the War.

THERE can be no doubt that the stream of private charity that flows with such ample tide in the British islands will be in no small amount diverted from its wonted channels. The cost of a great war is enormous both directly in life and treasure, and indirectly in the increased price of commodities. The surplus money of the nation, therefore, will be diminished so far as charitable disposal is concerned, and the actual sum available will be drained for the purpose of furnishing aid to our sick and wounded soldiers at the Cape and to their wives and families at home. The medical charities of the United Kingdom must perforce suffer from this unusual demand upon the generosity of the philanthropic public. Already instances of subscriptions withdrawn or curtailed on account of the war have been brought to the notice of hospital committees. For the present it is not easy to see in what direction one may look for a remedy to a somewhat alarming state of matters. If the worst comes to the worst we may perhaps still look hopefully to the inexhaustible benevolence that characterises our countrymen for

help to tide over the emergency. Or possibly the Government may extend national aid to the medical charities. There is another aspect of the subject that will commend itself to the Hospital Reform Association and kindred bodies, namely, that the medical charities should face the position and cut down their expenditure to the last penny in order to be ready for the years of the lean kine. A prudent reduction of the wholesale and indiscriminate relief granted in the out-patient departments would convert the position of many an institution from one of precarious struggle and beggary to that of comfortable competence and independence.

Sentiment and Philanthropy.

MUCH of England's manhood, and some of its best, is now in South Africa fighting for Queen and country, and much, we fear, is destined never to return. But, after all, the Empire is engaged upon a struggle which is necessary to its existence. Just as in the wars of the last century the nation was called upon to make many sacrifices, so now it may be, after many years of comparative peace, that the expenditure of English blood will prove, before the war ceases, to be a sore trial to the nation. In the midst of grief, however, there is always some consolation to be derived from taking measures to adopt some suitable means of perpetuating the memory of the dead, and in this connection, we may ask, could any more desirable method of doing so be suggested than that of endowing a bed at a hospital. By this means the name of a relative, killed in the service of his country, could be memorialised for ever afterwards in close association with a good work, and at the same time serve as an object lesson to every patient by whom the bed was occupied. This suggestion we commend to all those who, with wealth at command, may lose near relatives in the war of rebellion in South Africa.

Election of a Councillor of the Royal College of Surgeons, Ireland.

THE Fellows, on Monday last, proceeded to select a Councillor of the College in the room of Mr. Wheeler deceased. As we have already stated two candidates offered themselves—Mr. Ball Regius, Professor of Surgery in the University of Dublin, and Mr. Arthur Chance, Surgeon to the Mater Misericordiae Hospital. 224 voting papers were sent in, and, after the scrutiny of them, it was declared that Mr. Chance was elected, having scored 126 votes as against 98 for his opponent.

It affords as much pleasure to accede to the request of Messrs. Burroughs, Wellcome and Co., that we should inform our readers that they are supplying as a gift, the entire medical equipment of the City of London Imperial Volunteers throughout the present war in South Africa.

PERSONAL.

DR. ANDREW TURNER, Senior Assistant Physician at the West London Hospital, has resigned his post.

SIR JOHN WILLIAMS was entertained last week by the members of the Cardiff Medical Society, when he delivered an address on the present position of gynaecology.

MAJOR J. F. DONEGAN, R.A.M.C., who was left in Dundee in charge of the wounded on the retirement of the British troops, is now a prisoner in Pretoria.

SIR GEORGE ROBINSON SCOTT, K.C.S.I., Indian Medical Service, has retired from the Service, and intends to seek a Radical constituency with a view to entering Parliament.

DR. CONAN DOYLE, the popular dramatist and novelist, has, we understand, decided on relinquishing literature for the present, and will proceed in a few weeks to the front in charge of an ambulance hospital.

THE Executive Committee of the Liberal Association have nominated Dr. W. J. Collins, who is a graduate of the University and a former Chairman of the County Council, as Liberal candidate for the London University, consequent upon the elevation of Sir John Lubbock to the Peerage.

PROF. W. WATSON CHEYNE, F.R.S., F.R.C.S., and Mr. G. Lenthal Cheate, F.R.C.S., Surgeon and Assistant-Surgeon respectively to King's College Hospital, London who have left for the Seat of War, were entertained at dinner by the residents and students of King's College Hospital on Thursday last at the Hôtel Métropole.

MR. WATSON CHEYNE and MR. CHEATE left Waterloo for Southampton *en route* for South Africa on Saturday last, and the students of King's College Hospital gave them a hearty send off.

COMING events sometimes cast their shadows before, but, however that may be, the *New York Medical News* is rather "previous" in referring to Mr. George Brown, the direct representative on the General Medical Council, as "Sir" George Brown. Mr. Brown shares this honour with "Sir" Chamberlain and the late "Sir" Gladstone in the Continental Press.

H.R.H. THE PRINCE OF WALES presented on Saturday the service medals of the Order of St. John of Jerusalem to Mr. Samuel Osborn, F.R.C.S., Chief Surgeon of the Metropolitan Corps; Lieut. Chas. J. Trimble, L.R.C.P. Deputy Commissioner, and Mr. Chas. H. Tamplin, M.R.C.S., of Ramsgate, Hon. District Surgeon.

SIR WILLIAM GOWERS, Mr. Malcolm Morris, Dr. St. Clair Thomson, with several others, have left England on a visit to Sicily, where they are to inspect a palatial sanatorium recently erected for the treatment of phthisical patients. On the way they visited various scientific institutions at Rome and arranged for the establishment of systematic intercommunication between the Roman School of Hygiene and the London School of Tropical Medicine. The trip is expected to last about three weeks.

MEDICAL SOCIETY OF LONDON.

At the meeting of the Society on Monday evening last, Mr. Mansell Moullin reported two cases in which he had removed the vesiculæ seminales in young adults for tuberculous disease extending upwards from the epididymis. After removal of the testis and division of the cord as high up as possible with the patient in the lithotomy position, the under surface of the prostate and base of the bladder were exposed through a semilunar perineal incision running transversely. There was little bleeding in either case, but in one a small urinary fistula persisted for some months. He strongly advocated complete removal of the vesiculæ seminales and vas deferens in every case of tuberculous disease of the epididymis, in which the vesiculæ could be felt distinctly through the rectum.

Mr. Swinford Edwards observed that the operation was by no means a simple one, and suggested a modification of Kraske's operation.

Mr. Wallis also thought sufficient stress had not been laid on the technical difficulties.

Dr. Gow gave the result of a number of cases in which he had performed hysterectomy for fibroid with a mortality of about 2 per cent.

Dr. Blacker urged that with such a low rate of mortality many women might be now advantageously operated upon. He commented upon the gravity of adhesions, and related a case of his own in which they rendered removal of the tumour impossible. He agreed as to the desirability of preliminary ligation of the cervical tissue.

Mr. Wallis remarked on the extreme simplicity of the author's methods, which he suggested was the secret of his success, and Dr. Gow, in reply, pointed out that laceration of the uterus early in the operation caused bleeding which obliged them to rush the remainder of the operation.

Correspondence

We do not hold ourselves responsible for the opinions of our correspondents.

THE VALUE OF EMMENAGOGUES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It would, I think, be impossible for anyone who has seen the cases recently under treatment at the Westminster Hospital to doubt the efficacy of certain emmenagogues in the treatment of functional amenorrhœa associated with anemia. A chlorotic girl, æt. 19, comes before us with a history of having seen nothing for seven months. She is not pregnant, and there is no organic disease to account for her condition. She is put to bed, is fed on the best and most nourishing food, is given iron in full doses three times a day and the bowels are kept freely open. At the expiration of three weeks there is not a vestige of improvement. She is then put on manganese, her colour at once improves, and a fortnight later she menstruates freely. We find from an examination of the blood that it is a case of oligocythæmia with considerable oligochromæmia. Before the administration of the emmenagogue the blood taken from the finger (10.45 a.m.) is very pale in colour and contains only 3,830,000 red blood corpuscles per cmm. The colourless blood corpuscles number 3,000 per cmm. and consist chiefly of lymphocytes and finely granular oxyphil cells (polynuclear leucocytes).

This is the report after the cessation of the period:—

Blood taken from finger at 10.30 a.m. The drop appeared of good colour and flowed easily. Hæmaglobin 98 per cent.

Red blood corpuscles of good shape and uniform size, but a few megalocytes present. No nucleated erythrocytes found. Number = 4,725,000 per cmm, i.e. slightly above normal in the female.

Leucocytes between 11,000 and 12,000 per cmm. divided among varieties as follows:—

	per cent.
Finely granular oxyphil cells (multinuclear leucocytes)	71
Coarsely granular oxyphil cells ("eosinophil cells")	2
Large uninuclear cells "hyaline cells"	20
Lymphocytes	7

The number of hyaline cells is above, and that of lymphocytes below, the normal, but as there had been some considerable lapse of time since the last meal this is not extraordinary. In a word, the blood was in all respects like that taken from a healthy female.

Observations on other cases afford equally conclusive results.

These blood analyses are made not by me but by Dr. Lazarus Barlow, who has never seen the case and has no suspicion that anything new in the way of treatment is being attempted. What more in the way of proof is required I do not know, for the observations are made with all the care and accuracy of laboratory experiments. They show conclusively the value of emmenagogues in these cases, and illustrate incidentally the importance of having attached to a hospital a skilled pathologist, whose work cannot be influenced by any pre-conceived opinion as to the value of the remedial agents employed. I sometimes hear people say that they fail to obtain good results from the administration of emmenagogues, but it generally turns out on inquiry, that the drugs they are using do not belong to this class at all, but are only the reputed emmenagogues of the text-books.

The paper on permanganate of potassium in amenorrhœa by Dr. Ringer and myself was published in the early part of 1883, and our results have since been amply confirmed. My recent observations on the action of the soluble citrate are simply a development of the idea. On April 25th, 1894, you sir, were good enough to give hospitality to my paper on Senecio and Senecin. Dr. W. E. Fothergill's paper on the "Use of Senecio in Disorders of Menstruation," which obtained the Milner-Fothergill Gold Medal in Therapeutics in the University of Edinburgh, throws additional light on the subject.

I am, Sir, yours truly,

WILLIAM MURRELL.

Welbeck Street, W.

THE TEMPERANCE AND FOOD QUESTIONS AS THEY AFFECT HEALTH.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am much interested in the temperance and food question, and I venture to think they should be considered together. I have read Dr. Edmund's paper in your issue of December 6th. I know well how earnestly he has for many years advocated the temperance cause, and I wish he would also look into the question of food reform. They are both equally needed for the raising of society generally, for all want raising. The leaven of truth with respect to the food question is not yet working as it ought to work and as it doubtless will work before long. The process is necessarily a slow one. All advance is slow, whether with regard to individual discipline and freeing oneself from bad habits, which are as chains about so many of us, or with regard to national progress which is equally stereotyped. Every blow, however, sends the nail of truth deeper into the inert mass of blind prejudice which appears to be the rule of life with the majority.

I wish I could get Dr. Edmunds and many others to take up the food question. I can assure them there is a mine of interest in it for the true reformer, as well as a mine of health, when properly understood and practised. I can also say from personal experience that to discipline oneself conduces far more to peace and happiness, as well as to health, than to gratify one's appetites and passions, and it induces a condition of body and mind that robs life of half its worries by the peace and quiet that result to the whole system.

In my own person I have been testing these facts, and my experience of now over three years justifies me in saying that I believe there is an immense amount to be learnt from observations as to the effect of various dietaries with regard to health and disease. Such obser-

vations, however, are not and cannot be made in a hurry, or conclusions arrived at hastily; but they are, in my opinion, of such importance to all classes of the community, capable of thinking and reasoning, as to call for and justify any amount of trouble that will tend to the development and preservation of a sound mind in a healthy body to extreme old age. I may say that I am now in my seventy-seventh year, and that I hope at a future period to submit to the profession both myself and some interesting experiences which I have already accumulated, and that I am further working out and testing in my own person. In the meantime, perhaps, Dr. Edmunds will give us his views of vegetarianism from the standpoint of a philosophical epicure, minus personal experience.

I am, Sir, yours truly,
Kilburn Priory, C. J. HARRIS, M.R.C.S.
January 6th, 1900.

THE WAR—AN APPEAL TO THE YOUNGER MEMBERS OF THE PROFESSION.

THE following appeal has been sent us for publication:—

In the crisis through which our Empire is passing the importance of the Militia, Yeomanry, and Volunteer forces as a support to the army is fully evinced. And as it is impossible to forecast the further demands which may have to be made upon them in the near or distant future, it behoves us to strengthen them to the utmost of our power.

Many members and students of our profession are already enrolled in them and are answering the call now made upon them with patriotic promptitude. We venture to take the opportunity suggested by the beginning of the New Year of appealing to such of the younger members and of the students of the medical and dental professions as are still unattached, yet capable of bearing arms or in other ways of helping in Imperial defence, at once to consider the advisability of joining some branch of the service.

FREDERICK T. ROBERTS, M.D., F.R.C.P.Lond.,
Physician to University College Hospital;

EDMUND OWEN, M.B.Lond., F.R.C.S.Eng.,
Surgeon to St. Mary's Hospital;

WILLIAM COLLINGRIDGE, M.A., M.D.Cantab.,
Surgeon-Lieutenant-Colonel Militia Medical Staff; late commanding Militia Medical Staff;

WILLIAM DUNCAN, M.D.BruX., F.R.C.S.Eng.,
Captain Middlesex Yeomanry Cavalry;

J. EDWARD SQUIRE, M.D., M.R.C.P.Lond., M.R.C.S.Eng.,
Surgeon-Lieutenant-Colonel Commanding Volunteer Medical Staff Corps (London Companies).
London, Jan. 1st, 1900.

A DISCLAIMER.

To the Editor of THE MEDICAL PRESS AND CIRCULAR

SIR,—I have read your leaderette in THE MEDICAL PRESS AND CIRCULAR, January 3rd, 1900, prematurely condemning me for a supposed breach of professional etiquette, and stating that I had contributed a signed article to a trade journal called "The Dioptric and Ophthalmometric Review." I beg to state that I have neither contributed a signed nor unsigned article to the said journal on any subject, nor did I even know of the existence of such a journal until I saw it mentioned in yours this morning. I wrote a paper on "Tobacco Amblyopia" for *The Hospital*, a professional paper of recognised standing, which I find on inquiry was duly published in its issue of December 2nd, 1899. That is all I know of the matter.

Meanwhile, as you have given such publicity to the mis-statement, I shall expect you to give equal publicity to my denial of contributing a signed article to the aforesaid trade journal, and as you have also drawn the attention of the Ophthalmological Society, of which I am a member, to the matter, to also see that each member of that Society receives a marked copy of your issue containing my absolute denial.

I am, Sir, yours truly,
CLEMENTS HALLES, M.D., F.R.C.S.Edin.,
Bristol Eye Hospital.
Hawkesdale, Clifton, Jan. 4th, 1900.

[We regret that we should have been misled into supposing that our correspondent contributed the article direct to the trade journal mentioned. As, however, the article was "lifted" without acknowledgment he can compel the proprietors of the "Dioptric and Ophthalmometric Review" to pay him for this infringement of copyright.—ED.]

Laboratory Notes.

RECENT PHARMACEUTICAL PRODUCTS.

AMONG the recent additions to "new remedies" and "pharmaceutical elegancies" emanating from Messrs. Parke, Davis and Co., it may interest our readers to be made aware of the "Sterilised Concentrated Saline Solution," which, on dilution with a suitable quantity of pure water, forms a normal saline solution, ready for emergencies. Every surgeon and obstetrician ought to have a supply of these phials in his bag, ready for use as and when occasion may require.

The popular combination of Colchicine with Methyl salicylate is put up in neat little capsules for the treatment of gout and certain forms of rheumatism. These are small and well made, and each contains an average dose for repeated administration.

Of the fluid extract of Pichi we know less, but it has a reputation in the States of being a "tonic diuretic," contraindicated in organic disease of the kidneys, but very useful in stimulating diuresis, and assisting in the elimination of uric acid.

The object of the globules of Saw Pa'metto and Santal Oils is too obvious to require mention. They represent a very useful combination, and we have found them very serviceable in vesical and urethral conditions calling for this kind of medication. This combination offers several advantages over the remedies most in vogue.

The uniformity of weight, and the finish of Messrs. Parke Davis and Co.'s products call for special commendation, and they must commend themselves to the favourable notice of fashionable practitioners.

Literature.

DE MERIC'S FRENCH-ENGLISH MEDICAL DICTIONARY. (a)

THIS volume completes the English-French, French-English Dictionary of Medical Terms, the first volume whereof was favourably noticed by us early last year. In compiling such a work it is, of course, very difficult to decide where to draw the line in the selection of words. It is obviously very difficult to limit the selection to words which are essentially and exclusively afferent to medicine and the allied sciences, and the author appears to have made up his mind not to err on the side of exclusion, though even then one is surprised to see such words as *mauvais*, *mid*, *mineral*, *cog*, and the like. No one, however, will grumble at a dictionary on the ground that it gives more information than was bargained for, while on the other hand, the patience, skill, and erudition of the author are testified to by the extraordinary range of his vocabulary.

Although many of the terms are as unfamiliar to us in English as they assuredly are in the French original, it is impossible to deny that the author has exhausted his subject, and his work will remain as a monument from the stones whereof less ambitious compilers may, at their leisure, build up less comprehensive works.

In spite of close scrutiny we have been unable to discover any inaccuracies or indeed, anything calling for adverse criticism. The book is smaller than its companion for reasons given in the preface, it is admirably printed, and the choice of types has been most judicious.

(a) "Dictionnaire des Termes de Médecine, Français-Anglais." Par H. de Meric, M.R.C.S.Eng., Chirurgien de l'Hôpital Français à Londres, &c. Part II., completing the work. London: Baillière, Tindall, and Cox. 1899. Price 4s. net.

We congratulate the author on the termination of what must have been a very trying and arduous task.

NUNN ON CANCER. (a)

In this little book the author has re-arranged observations and facts published in his "Essay on Cancer of the Breast." After a few words on the structure of cancer (which is well illustrated by plates at the end of the work) Mr. Nunn deals with the life history of the disease, dividing it into the initial, the transient, or dynamical, and the final, or obsolete. He then gives interesting short accounts of regional frequency, the age of greatest liability or vulnerability, geographical distribution, and heredity and longevity. The work is completed by the histories of fifty-three interesting cases, and by eleven very excellent plates of microscopical sections.

ENLARGEMENT OF THE PROSTATE. (b)

A SECOND edition of this practical work is very welcome. In it the author has omitted those operations on the prostate described in the first edition which were chiefly of historic interest. Many of the other chapters, however, have been lengthened, especially the one on the effects of enlargement of the prostate, the one on diagnosis, the two on local treatment of enlargement of the prostate, whilst a very complete résumé of the effect upon enlargement of the prostate, orchidectomy and of operations upon the structures contained in the spermatic cord takes the place of the short chapter on castration. The book at present is certainly a very complete and up-to-date epitome of the surgery of the prostate.

The Medical Sickness and Accident Society.

THE usual monthly meeting of the Executive Committee of the Medical Sickness, Annuities, and Life Assurance Society was held at 429, Strand, London, W.C., on 29th ult. In the absence of the Chairman, Dr. de Havilland Hall, the chair was occupied by Dr. Major Greenwood, and there were also present Dr. J. B. Ball, Mr. J. Brindley James, Dr. W. Knowsley Sibley, Mr. F. S. Edwards, and Mr. Edward Bartlett. The accounts showed that during 1899 the Society had disbursed in sickness pay a larger amount than in any previous twelve months of its working. As the number of the members and their average age have grown year by year, the amount of sickness expected and provided for by the tables has necessarily grown with them. So far, the ever-increasing annual payments for sickness have always been within the expectation, and every year's account has shown a solid addition to the large pecuniary reserves of the Society. The committee had to regret the loss they have sustained through the death of Mr. H. R. Jennings, who has been auditor of the Society since it started in 1884. His successor will be elected by the members at the general meeting in May next. Prospectuses and all information on application to Mr. F. Addiscott, Secretary Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

Another Dispensing Mishap.

DR. WILLIAM J. BELCHER, Medical Officer to the Bandon Workhouse, died on Saturday, the 29th ult, in consequence of his having accidentally swallowed carbolic acid by mistake for solution of magnesia, when mixing a draught for his own use. Medical aid was promptly summoned, but the unfortunate gentleman died before Dr. Reid arrived. Dr. Belcher, who was 62 years of age, belonged to an old Bandon family, and was extremely popular. He leaves a widow and several children to mourn his loss.

Deaths in the Profession.

THE death is announced of Dr. John Gardner Dudley, of Hove, Brighton, at the age of 71. Dr. Dudley took his degree at Cambridge in 1860 and was physician to

the Metropolitan Free Hospital for upwards of twenty-four years, afterwards being appointed consulting physician to the North London Consumption Hospital and other institutions. The death is also announced of Surgeon-Major Alexander Grant, at the age of 82, who saw a good deal of active service in Bengal, retiring in 1869. He was appointed honorary surgeon to the Queen in 1861. We have also to chronicle the death of Deputy-Surgeon-General David Cullen, who served in the Army Medical Department from 1854 to 1869. He was present at the siege and fall of Sebastopol, and during the Indian Mutiny he assisted at the capture of Lucknow.

The Sick and Wounded.

According to the *Times* an important scheme has now been completed on the Riviera by which practically all the leading hotels, besides many owners of villas, have agreed to receive as free guests convalescents from the Transvaal. Officers can obtain full information from the secretary, Transvaal Convalescents' Office, *Anglo-American Gazette*, Nice.

Munificent Bequests to Manchester Hospitals.

By the death of Mr. Gledhill, of Manchester, a director of Armstrong, Whitworth, and Co., the undermentioned medical charities have become recipients of the following:—The Southport Convalescent Hospital and Sea Bathing Infirmary, £2,000; the Huddersfield Infirmary, £1,000; Manchester Southern Hospital for Women and Children, £1,000; St. Mary's Hospital, Manchester, £1,000; Royal Eye Hospital, Manchester, £1,000; Hospital for Consumption in Manchester and Bowdon, £1,000; the Barnes Convalescent Home, £1,000; Ancoats Hospital and Ardwick and Ancoats Dispensary, £500; General Hospital and Dispensary for Sick Children, Pendlebury, £500; the Working Men's Christian Institution and Medical Mission Dispensary, Redbank, £500; St. John's Ambulance Association, Manchester Centre, £500; the Manchester and Salford Sick Poor and Private Nursing Institution, High Street, £250; the Openshaw Provident Dispensary, £250; Royal Albert Asylum for Idiots at Lancaster, £500; Northern Counties Hospital for Incurables, £500; Manchester Eye and Ear Hospital, £500; Manchester and Salford Lock Hospital, £250; and the Dispensary for Women and Children at Ancoats, £250.

PASS LISTS.

University of London.

AT the B. S. Examination for Honours in Surgery held last month, the following candidates passed:—

FIRST CLASS.

Bucknall, Thos. Rupt. H., M.D., London Hospital, Stevenson, Mabel G' (Gold Medal), Royal Free Hospital, Trotter, Wilfred B. L., M.D. (Scholarship and Gold Medal), University College, Turnbull, Jane Holland, Royal Free Hospital.

SECOND CLASS.

Turner, Philip, B.Sc., Guy's Hospital.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—The following candidates having passed the necessary examinations have been admitted Fellows of the College, their names being arranged in order of seniority of membership:—

Hugh James Moore Playfair, M.D. Lond., M.R.C.P. Lond., member July 31st, 1890; Herbert William Carson, L.R.C.P. Lond., member July 29th, 1895; Evan Lancing Evans, M.A., M.B., B.C. Camb., L.R.C.P. Lond., member November 14th, 1895; Percy Samuel Lelean, L.R.C.P. Lond., member November 14th, 1895; John Howell, M.B. Lond., L.R.C.P. Lond., member February 13th, 1896; William Francis Victor Bonney, M.D., B.S. Lond., L.R.C.P. Lond., May 14th, 1896; Thomas Rupert Hampden Bucknall, M.D. Lond., L.R.C.P. Lond., member August 4th, 1896; Wilfred Batten Lewis Trotter, M.D. Lond., L.R.C.P. Lond., member August 4th, 1896; Arthur Murray Cudmore, M.B., Ch.B. Adel., L.R.C.P. Lond., member November 12th, 1896; Charles Ralph Keyser, L.R.C.P. Lond., member August 4th, 1896; Gilbert Smith, M.B. Durham., L.R.C.P. Lond., member August 4th, 1896; Rodolph de Salis Stawell, B.A., M.B., B.C. Cantab., L.R.C.P. Lond., member August 4th, 1896; John William Thomson Walker, M.B., C.M. Edin., L.R.C.P. Lond., member August 4th, 1896; Herbert Mundy, L.R.C.P. Lond., member May 13th, 1897; Robert Gow Balston, M.B., C.M. Edin., L.R.C.P. Lond., member May 13th, 1897; Frank Mannington, L.R.C.P. Lond., member July 29th, 1897; Joseph Oliver Skevington, L.R.C.P. Lond., member February 10th, 1898; Edred Moss Corner, M.B., B.C. Cantab., M.A., B.Sc. Lond., L.R.C.P. Lond., member May 4th, 1898; Thomas Joseph Patrick Hartigan, L.R.C.P. Edin., member May 4th, 1898; John Law Adams, M.B., C.M. Aber., member November 10th, 1898; and Arthur Ferguson MacCallum, B.A., B.C. Camb., L.R.C.P. Lond., member November 10th, 1898.

Seventeen candidates were referred to their professional studies.

(a) "Cancer." By J. W. Nunn. Pp. 38. Henry J. Glaiser, London, 1899.

(b) "Enlargement of the Prostate: Its Treatment and Radical Cure." By C. Mansell Moulin. Second edition. Pp. 235. H. K. Lewis, 1899.

Notices to Correspondents, Short Letters, &c.

✎ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

LOCAL REPORTS AND NEWS.—Correspondents desirous of drawing attention to these are requested kindly to mark the newspapers when sending them to the Editor.

READING CASES.—Cloth board cases, gilt lettered, containing twenty-six strings for holding the numbers of THE MEDICAL PRESS and CIRCULAR, may now be had at either office of this journal, price 2s. 6d. These cases will be found very useful to keep each weekly number intact, clean, and flat after it has passed through the post.

ORIGINAL ARTICLES or LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

REPRINTS.—Authors of papers requiring reprints in pamphlet form after they have appeared in these columns can have them, at half the usual cost, on application to the printers before the type is broken up.

COUNTY PRACTITIONER (Fyford).—Acetylene, even under existing circumstances, is a very economical and satisfactory method of illumination for dwellings far removed from a supply of coal gas. Experiments have shown that acetylene is only half as explosive and only a quarter as poisonous, as coal gas; indeed, for an escape to give rise to an explosion on the approach of a light the air must contain not less than 40 per cent. of the gas, an enormous proportion in view of its powerful odour. Acetylene attacks copper, for which reason brass fittings are disadvised, and the use of rubber tubing is dangerous to a degree.

N. B. O.—Great Britain stands second on the list of beer-drinking nations, with its 145 litres per head per annum, Belgium taking the first place with 170 litres, and Germany coming third with 116 litres. In France the quantity falls to 22.5. In Switzerland the figure is 55.

L.S.A.—Writes to ask whether, in view of the recent action of the General Medical Council, he is justified in calling himself physician and surgeon. To our mind he is, but we cannot accept the responsibility of advising him to use those titles. There is a house in a main street not a hundred miles from Harley Street itself, where a gentleman has on his brass plate "L.S.A.Lond., Medical Practitioner." It would tax the powers of any authorities to prosecute so ingenious and ingenious a gentleman. In that way lies safety.

WANTED, A REMEDY FOR ALOPECIA.

AN "old practitioner" asks what are the best remedies for alopecia in middle age with some greyness of hair and dandruff. From this scant description the case appears to be seborrhoeic. If so, the class of remedies, broadly speaking, that will be of service are of the stimulant and antiseptic class, e.g., cantharides and salicylic acid. Cleanliness is essential, together with careful attention to the general health.

RUS IN URBE (Yorks).—The preparation is a patent one. Its chief ingredients are two drugs in daily use in general practice, and there is absolutely no advantage in the advertised preparation over that which is made up according to a medical prescription. The cost of the protected compound is enormously disproportionate to its value. The name of the preparation is mentioned in a standard work on the diseases of the skin recently issued, and we are more than surprised that such should be the case.

Meetings of the Societies and Lectures.

WEDNESDAY, JANUARY 10TH.

HUNTERIAN SOCIETY.—8.30 p.m. Paper.—Dr. D. Grant: Cases illustrating various Conditions giving rise to Deafness (with demonstration of cases).

THURSDAY, JANUARY 11TH.

BRITISH GYNÆCOLOGICAL SOCIETY (20, Hanover Square, W.).—8 p.m. Specimens will be shown by Dr. A. Giles, Dr. Purcell, and Dr. F. Edge. Annual Meeting. Election of Officers, &c. President's Valedictory Address.

FRIDAY, JANUARY 12TH.

CLINICAL SOCIETY OF LONDON (20, Hanover Square, W.).—8.30 p.m. Clinical Evening. The following cases will be shown.—Mr. J. Hutchinson, jun.: Complete Sub-peritoneal Resection of the Oes Calcas.—Mr. Lunn: (1) A Case of Double Facial Diplegia in a Woman; (2) Congenital Luxation of the Right Hip in a Child, with Skiagraph; (3) Faroxysmal Hemoglobinuria in a girl of 10 years.—Mr. C. J. Symonds: Malignant Disease of the Thyroid after two Operations.—Mr. Jackson Clarke: Case of Excision of the Neck of the Lower Jaw for Ankylosis.—Other cases will be shown. Patients will be in attendance at 8 p.m.

BRITISH LARYNGOLOGICAL, RHINOLOGICAL, AND OTOLOGICAL ASSOCIATION (11, Chandos Street, Cavendish Square, W.).—4 p.m. Meeting.

Vacancies.

Brecon Infirmary, South Wales.—Resident House Surgeon, unmarried. Salary £90 per annum, with furnished apartments, board (all found except beer), attendance, fire, and gas.
County of Sutherland.—Medical Officer of Health for the County of Sutherland. Salary £300 per annum, and £50 in lieu of travelling and other expenses, with certain exceptions. Applications to the County Clerk, Golspie.
General Hospital, Nottingham.—House Surgeon for two years. Salary commencing at £100, with board, lodging, and washing.
General Infirmary at Leeds.—Resident Casualty Officer. Salary £100 a year, with board, lodging, and washing. Also House Physician for six months, board, lodging, and washing provided.
Glamorgan County Asylum, Bridgend.—Junior Assistant Medical Officer, unmarried. Salary £150, with board, apartments, washing, and attendance.
Metropolitan Asylums Board.—Assistant Medical Officer at the Imbecile Asylum at Caterham, Surrey, unmarried. Salary commencing at £120, with board, lodging, attendance, and washing. Apply to the Clerk to the Board, Norfolk Street, Strand, London. (See advt.)
Northampton General Infirmary.—Assistant House Surgeon, unmarried. Salary £100 per annum, with furnished apartments, board, attendance, and washing.
Parish of Gairloch, Ross-shire.—Medical Officer. Salary from the Parish Council £200 per annum, besides private practice. To reside at Poolewe. Apply to Mr. James Mackintosh, Inspector of Poor, Poolewe.
Three Counties Asylum, near Hitchin.—Second Assistant Medical Officer. Salary £150 per annum, with board, apartment, washing, and attendance. Unmarried. Apply to the Clerk, St. Neas Hunts.
Whitehaven and West Cumberland Infirmary, Whitehaven.—House Surgeon. Salary £120 per year, and £30 a year for dispensing, with furnished apartments and attendance.

Appointments.

HARVEY, B.A. Cantab., M.B., C.M.E.D., Resident Medical Officer to the Hertford British Hospital, Paris.
BAUMANN, E. P., M.B. Edin. M.R.C.S.Eng., House Surgeon to the Glasgow Maternity Hospital.
BUCKLEY, L.S.A. Medical Officer for the Hasland Sanitary District of the Chesterfield, Derby, Union.
BROWN, ALFRED, M.D., M.R.C.P., Honorary Physician to St. John's Hospital for Diseases of the Skin, London.
GILES, ARTHUR E., M.D., B.Sc.Lond., M.B., B.Ch.Vict., F.R.C.S., Edin., M.F.P.P.Lond., Gynaecologist to the Tottenham Hospital.
HARRIS-JONES, E., M.B., C.M.E.D., Resident Surgical Officer to the Birmingham and Midland Eye Hospital.
JOHNSON, P., L.R.C.P., L.R.C.S. Edin., L.F.P.S. Glasg., Medical Officer of Health for the Borough of Stoke-on-Trent.
LAWSON, T. C., M.R.C.S., Medical Officer and Public Vaccinator for the Longtown Sanitary District of the Longtown Union.
PEARCE, F. H., L.R.C.P.Lond., M.R.C.S., Senior Assistant Medical Officer for the Workhouse, Bradford.
ROCHE, T. F., L.R.C.P., F.R.C.S. Edin., L.F.P.S. Glasg., Medical Officer for the Penarth Sanitary District.
SAVILLE, THOMAS, M.D., M.R.C.P., Honorary Physician to St. John's Hospital for Diseases of the Skin, London.
SEACOMBE, A. F., L.R.C.P., L.R.C.S. Edin., L.F.P.S. Glasg., Resident Medical Officer of the Workhouse, Toxteth, Liverpool.
UNDERHILL, S. Y. H., L.R.C.P., M.R.C.S., House Surgeon to the Suffolk General Hospital at Bury St. Edmunds.

Births.

COSENS.—On January 3rd, at 49, Oxford Terrace, London, W., the wife of C. H. Cosens, M.R.C.S., L.R.C.P., of a daughter.
DOW.—On January 4th, at High Street, Lewes, Sussex, the wife of William A. Dow, M.D., of a daughter.

Marriages.

MANNINGTON—CLARKE.—On January 4th, at Hawkhurst, Frank Mannington, F.R.C.S., of Muswell Hill, to Lillian, second daughter of E. R. Clarke, of Hawkhurst.
MEAKIN—BALL.—On January 6th, at St. Giles's Church, Cambridge, Harold B. Meakin, M.D., Indian Medical Service, to Frances Amelia, elder daughter of Sir Robert Ball, Observatory, Cambridge.
WATSON—BARRETT.—On January 3rd, at Norwich Cathedral, Charles E. Watson, M.D. Brux., M.R.C.S.Eng., of Tunbridge Wells, to Grace Elepheth, daughter of Rev. Canon Barrett, of Lincoln.
WRIGHT—NORRISH.—On January 4th, at the Parish Church, Crediton, Samuel B. Wright, L.R.C.P., M.R.C.S., of Romford, Essex, to Annie Jane, daughter of D. M. Norrish, Esq., of Fowton, Crediton.

Deaths.

DUDLEY.—On January 2nd, at 63, Hova Villas, Brighton, John Gardner Dudley, M.A. M.D., M.R.C.P., formerly of 71, Belgrave Road, London, aged 72.
TAYLOR.—On January 6th, at Mattishall, Norfolk, George Taylor, M.R.C.S., J.P., aged 82 years.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXX.

WEDNESDAY, JANUARY 17, 1900.

No. 3.

Original Communications.

EXCISION OF THE VESICULÆ SEMINALES FOR TUBERCULOUS DISEASE. (a)

By C. MANSELL MOULLIN, F.R.C.S.,

Surgeon and Lecturer on Surgery to the London Hospital, &c.

IN discussing the question of the operative treatment of the early stages of tuberculous disease of the bladder during the last session of the Medical Society, I suggested that, if in any case in which the disease was limited to one side, it seemed probable that the infection was spreading upwards from the epididymis to the vesicula seminalis, it would be advisable to remove this organ as well as the testis, and in this way prevent, or at the least lessen the chances of, the extension of the tubercle to the prostate and the base of the bladder. I had before then removed one of the vesiculæ for chronic inflammation consequent upon gonorrhœa, and satisfied myself that the operation presented no exceptional difficulty, but I had not then met with a case of tuberculous disease in which such a proceeding as this appeared to me to be suitable. Since then I have performed this operation twice with this object, and the result in each case has been excellent, the patient making a good recovery, and, to all appearance being freed from a source of infection which, if left, would have extended to the bladder and caused intense suffering and death.

One of these cases was at hospital. The patient was twenty-two years of age. Last Easter he noticed that the left testicle was becoming enlarged and painful. Three weeks before admission the skin of the scrotum had given way. On admission there was advanced tuberculous disease of the epididymis with a sinus in the scrotum. The vas deferens was thickened and the vesicula seminalis of the same side hard and nodular. There did not appear to be any tuberculous disease elsewhere. The testis was removed on July 4th. An oval incision was made in the scrotum so as to include all the involved tissues, and continued up the groin. The inguinal canal was laid open, the cord ligatured at its highest accessible point, the whole mass removed, and the wound sutured. The patient was then placed in the lithotomy position with the buttocks very much raised, and the under surface of the prostate exposed through the perineum by means of a modification of Zuckerkandl's incision. This consists of a transverse division of the perineum through or immediately behind the centrum tendineum, with a prolongation from each end backwards and slightly inwards into the ischio-rectal fossa, so far as may be found necessary. Instead of this I made a semilunar incision with the concavity towards the anus. This divides the super-

ficial perineal vessels and nerves, but avoids any danger to the artery to the bulb unless this takes some unusual course. If more room is wanted the backward prolongation on the affected side can be made rather longer, but I have not found this necessary. The external sphincter is detached; the rectum pressed down into the concavity of the sacrum, and the fibres of the levator prostatae divided. All that then remains is the layer of the recto-vesical fascia which passes behind the vesiculæ seminales, and keeps them against the posterior surface of the bladder. I have not found any difficulty with the prostatic plexus. If the division of this fascia is made in the middle line above, or on a level with the upper limit of the prostate, there is little or no fear of injuring it, at least, in young subjects. If now, firm pressure is made over the pubes by an assistant, the prostate, the posterior surface of the bladder, and the vesiculæ seminales are brought within easy reach of the finger, and can be manipulated without difficulty. It is better that the bladder should not contain any urine, and I have not found any benefit from a catheter tied in the urethra.

In the present instance the vesicula was separated from the under surface of the bladder, hooked well forward, and the vas deferens divided as high up as possible. In doing so the ejaculatory duct was torn out from the prostatic urethra, laying this open. The slit in the urethra was sutured with catgut; the wound plugged with iodoform gauze to prevent any venous oozing, and the sphincter ani united to the centrum tendineum by a silk-worm gut suture. The superficial wound was closed with catgut. There was very slight shock. The temperature rose on one occasion to 101 degs. F., but soon fell again. At first, the urine came almost entirely through the wound. A fortnight after the operation he passed twenty-five ounces through the urethra, and after this it nearly all came the right way, but there is still a small fistula through which a few drops exude during micturition. The bowels were opened by enema five days after the operation, and there was never any loss of control over the sphincter. The part removed included the whole of the vesicula seminalis with the dilated portion of the vas deferens. The interior was full of breaking down caseous masses, but the disease did not appear to have penetrated through the wall, or to have involved the cellular tissue around.

The other case resembled this one so closely in all material particulars that there is no occasion to give a separate description. The epididymis was large and hard, but the caseous deposit had not yet broken down, so that there was no occasion to excise any portion of the scrotum. Two modifications were made in the method of operating. One was the removal of the whole of the vas deferens, part of which in the former case had been left behind. Two ligatures were used in the preliminary castration, one for the vas by itself, the other to include the other

(a) Paper read before the Medical Society of London, Monday, January 8th, 1900.

structures in the cord, and the vas was separated from its surroundings so far as it could be through the internal abdominal ring. The same was done for its lower end where the vesicula had been exposed through the perineal opening, and by careful traction the whole of the remaining portion of the vas was withdrawn together with the vesicula. The other modification was the placing of a ligature around the ejaculatory duct to prevent any escape of urine into the wound. In the first case I question whether this would have been feasible owing to the extent to which the vesicula was affected. In this one it succeeded in so far that the wound closed up without any trouble after the packing had been removed. The disease was of the same character, but hardly so far advanced as in the former case. Recovery was uneventful.

This operation does not appear to have been performed upon many occasions, and in the majority of these the immediate cause appears to have been induration and persistent pain consequent upon gonorrhoeal inflammation. I can find very few cases recorded, none in England, in which it has been done for tuberculous disease, although there are a few in which caseous deposits have been scraped out. Ullman on one occasion removed both vesiculae for tubercle; and in this case, as in the first one of mine, the ejaculatory duct was divided in the substance of the prostate, and a small fistula persisted. Roux has operated twice, and Fenger, Schede, and one or two others each once. Zuckerkandl's incision, or the modification of it which I adopted, appears to me to be by far the best. Roux recommends a lateral incision on the affected side, two or three centimetres from the middle line, reaching as far back as the ischium, and exposing the rectum freely. The patient is placed in the lithotomy position, but lying upon the side rather than upon the back. Pressure exerted from the rectum is made use of for the purpose of bringing the upper edge of the vesicula into the wound. But the small size, and the great depth of the wound makes access very difficult. Von Dittel's incision which follows the same direction, but begins with a curve in front of the anus, gives more space. But unless the perineum is very deep, or the suprapubic region very rigid, neither of which is probable in young subjects affected with tuberculous disease, there is no difficulty in exposing the part thoroughly through Zuckerkandl's; and this has the further advantage that if there is any question about the condition of the other vesicle, it can be examined without difficulty.

I do not suppose that this operation will be often performed. A fair number of cases of primary tuberculous disease of the vesiculae seminales has been recorded, and these, of course, would be the most suited to an operation of this kind, but it is probable they are not nearly so common as the number of those which have been published would imply. And the operation is not required when the disease is limited to the epididymis, and is almost useless when it has extended beyond the vesiculae and invaded the surrounding structures. A portion of the prostate has, it is true, been excised at the same time in one instance, and in another a caseous focus was felt and scraped out; but this must be nearly the limit. There remain, however, a considerable number of cases in which, at a certain stage, the disease has extended into the vas, but has not yet involved the prostate to any serious extent, or the base of the bladder; and these cases can be diagnosed with a very fair degree of certainty, for the existence of tuberculous deposit in the vesiculae can be felt without any difficulty through the rectum; in such as these I believe this operation to be not only justifiable, but strongly to be recom-

mended and even to be urged, provided, of course, the lungs and other organs are not seriously involved. Without exposing the patient to too great a risk it gives him one more chance of being freed from a disease which, when it has once reached this stage, will, if it is left to itself, inevitably progress and ultimately cause death with the greatest suffering.

NOTES ON RECENT CASES OF ENTEROPTOSIS. (a)

By A. A. SYMONS ECCLES, M.B.

THE four following cases have been selected from twenty-two examples of enteroptosis recorded in my note-book for 1899, because they illustrate very definitely the causes and effects of Glénard's disease, (b) corresponding closely to the typical conditions described by the French physician who has given us the first and best account of a malady which has not received the attention and serious consideration in this country it appears to me to demand.

The two first cases belong to the class which has been by far the most numerous in my own practice, the sufferers having passed through the stages of (1) simple dyspepsia without local abdominal physical signs, (2) difficult or disordered digestion with the local signs of enteroptosis, and (3) the neurasthenic symptoms consequent thereon. The other two cases are also briefly noted, as they seem to come under the category of primary enteroptosis not preceded by dyspepsia without downward displacement. In regard to the first two cases it may not be easy to insist on the absence of enteroptosis at the outset; but looking to the history and sequence of symptoms it may be fairly stated that evidence of any downward displacement of viscera is in these and similar instances not forthcoming till after a certain period has elapsed.

CASE I.—Mrs. —, æt. 39, was sent to me early in the summer by Professor Clifford Allbutt, who had diagnosed the existence of enteroptosis and enjoined the recommendation that the patient should not be informed of the local conditions. For more than eighteen months there had been gradually failing health with increasing neurasthenia, preceded by epigastric distension, acid eructations shortly after meals, and tasteless flatulence immediately on taking food.

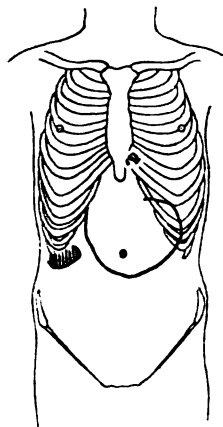
The appetite had been good, but the discomfort following meals had led to restriction of diet as when the stomach was empty no discomfort was felt. Gradually, however, and more especially during the past twelve months the symptoms had altered in character, for in addition to the immediate expulsion of gas when food was taken, there followed some two or three hours after meals a sense of weight and oppression of the epigastrium with dragging pain in the back, and an intolerable feeling of inertness sometimes relieved after gurgling or flatulence.

The indigestion would sometimes pass away quickly, at others the heaviness lasted till the next meal, when for a time varying from half-an-hour to two hours some ease was obtained only to be followed by another bout of discomfort always accompanied by great weariness. Meanwhile the bowels, which had previously acted regularly, became more relaxed, and for a time there was diarrhoea, alternating with scybalous motions.

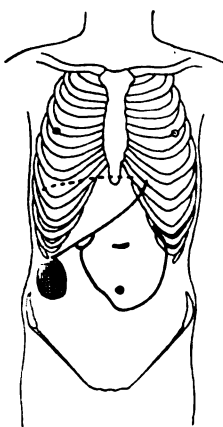
Headache, vertical and occipital, asthenopia, insomnia due to flatulence, and various neurasthenic symptoms, with loss of weight and strength, rapidly

(a) Read before the Chelsea Clinical Society, December 19th, 1899.
(b) "Application de la Méthode Naturelle l'Analyse de la Dyspepsie Nerveuse. Détermination d'une espèce." Frantz Glénard, *Lyon Medical*. Vol. 48, 1885. P. 449 et seq.

becoming worse in the three months preceding the date on which I received this patient for treatment, brought her under my observation when all the symptoms recorded above were present with the physical signs of enteroptosis. The epigastric region was scaphoid with little, if any, bulging of the flanks or hypogastrium. A distinct splashing sound could be elicited on palpation over the epigastrium from the level of the seventh left costa in the mammary line across to the inner edge of the right ninth costal cartilage, thence downwards to the level of the navel and upwards to the left hypochondrium again. With the stethoscope in the seventh left interspace just inside the mammary line, the wave could be distinctly heard and felt when the hand was pressed gently upwards against the greater curvature of the stomach lying just below the navel. The right kidney was freely movable, on deep inspiration occupying the position shown in the diagram.



CASE I.—DIAGRAM I.



CASE I.—DIAGRAM II.

Examination per rectum revealed the existence of sigmoid prolapse, a distinct protrusion of the pelvic loop into the rectum being felt when the patient strained, and through the anterior rectal wall small globular faecal masses could be recognised lying in the flaccid bowel. For some time this patient had suffered from enuresis, varying in severity, and until the relief of the enteroptosis was accomplished frequent micturition night and day prevented her from obtaining rest.

The position of the viscera as described refers to the recumbent attitude; their further down-dropping is shown in diagram II, when the patient assumed the vertical or standing posture.

At the conclusion of five weeks treatment the weight had risen from 7 st. 3 lbs. on admission to 8 st. 5½ lbs., and the organs were no longer dislocated downwards. Only the lower third of the right kidney could be felt on deep inspiration, and the stomach lay well above the navel. One further remark may be made on this case. There was marked low tension, the pulse was 96 at first, then 84, small and easily compressible until the third week of treatment, when it gradually increased in tone and volume, the rate in the recumbent position being reduced to 70, and never rising more than 14 beats per minute on the assumption of the erect position. The patient was furnished with a hypogastric belt on leaving my care. I have heard within the past few days of her good health and spirits.

CASE II.—Miss —, æt. 60, was sent to me by Dr. Shann, of Lowestoft, complaining of depression, gloom and prostration, everything that happened being felt in the stomach. Indigestion with great distension and flatulence occurs two hours after each meal and follows directly on any emotion or fatigue.

This has continued for many years, and has become much worse for the last two years. The tongue was flabby and coated with pale fur. The appetite was nil, and food had been reduced to a very small quantity, on account of the flatulence, dragging and gnawing pain through to the back, and the intolerable sense of weight in the epigastrium, followed by constant unrest and irregular localised distension of the bowels whenever food was taken.

Epigastric pulsation, and "a sensation of everything being blocked," also caused great distress. The bowels were only relieved by the use of aperient, glycerine suppositories, and enemata.

The abdomen was thin walled, and very flabby, with marked protrusion of the hypogastrium and hollowness of the epigastrium, greatly exaggerated when the patient stood up.

On palpation the aortic pulsation was easily felt between the xiphoid cartilage and the navel, just above the umbilicus a firm thick cord could be felt crossing from the left to the right hypochondrium.

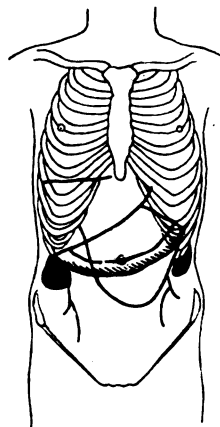


DIAGRAM III.

Below the navel and occupying the position shown in the diagram the splash sound was very easily elicited; by percussion and ausculto-palpation the limits of the stomach were found to be enlarged and displaced downwards, especially to the left. The right kidney was freely movable, the left could also be felt more than normally on deep inspiration. Examination per rectum revealed a roomy bowel with great redundancy of the mucous membrane, which hung in loose folds and made it difficult to reach the entrance to the sigmoid flexure. Subsequent examination proved the existence of some degree of entero-stenosis here as in the transverse colon.

The heart sounds were excellent; but with a splendid ventricle the pulse was low. Extremities cold. There were rûles at both bases. Sleep was good for the first part of the night, but the patient always awakened at, or about, 2 a.m., and obtained no sleep later.

Previous illnesses.—Acute gastritis at the age of fourteen, between the ages of seventeen and nineteen constant gastric disturbance and emaciation followed ever since by chronic invalidism due to failure of digestive powers. An operation by Mr. Allingham for prolapsus ani, had greatly improved the bowel troubles, but constipation still existed.

Here then is a typical case of Glenard's disease, gastritis, dyspepsia, presumably, without local physical signs followed by emaciation, marked evidence of enteroptosis, entero-stenosis, and as a consequence nervous and muscular prostration.

This lady had not given way to her digestive troubles; for many years she drove, rode, and walked,

suffered much disappointment, but throughout maintained a brave and buoyant disposition, until the loss of rest, caused by conscious digestion and all the evils of malnutrition, so affected her life that she was anxious to carry out the wishes of her medical adviser and come under my care for treatment which has not yet concluded; but so far, I may say, sleep is more lasting at night and rarely less than six hours' in duration with a short interval of awakening. The sense of stoppage no longer is felt, though the atony of the stomach and bowels still makes of digestion a conscious effort. A daily motion is obtained with the use of a diluted glycerine injection. There is no longer any pain or gnawing in the epigastrium, nor is there any depression of spirits.

The abdomen is more normal in the shape and texture of the walls, and the stomach now shows that it is capable of contracting on its contents, while the intestines, though feeble and slow in their peristaltic action, no longer fail to impel matters which formerly could be felt accumulating in the transverse, descending, and pelvic colon. Very little weight has been gained, but there is decided increase in vigour and vitality.

The next two cases are examples of primary enteroptosis.

CASE III.—Miss —, æt. 26, was recommended to consult me by Dr. P. S. Abraham, under whose care she was for a skin affection. My friend, Dr. Abraham, had diagnosed right nephroptosis, and when we saw his patient together he agreed with me that there was also gastroptosis and left nephroptosis. When this lady came under my close observation in the early part of this year it was plain to see that enterostenosis existed at the hepatic and splenic flexures of the colon, and I could sometimes feel the transverse colon on deep pressure in the situation depicted in the diagram. The patient complained of pain in the left lumbar region and in the umbilical region, also over the ninth and tenth dorsal vertebræ and the corresponding left ribs. This pain came on from an hour to three hours after meals and when very tired, as she always felt in the afternoon, it was most severe.

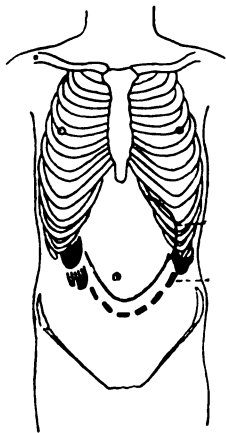


DIAGRAM IV.

When she starved she was comfortable. She first noticed the pain suddenly in the left side "like a violent stitch in the side, which doubled her up" while climbing in a mountainous district, and for six months a pain like toothache in the left side and back, becoming worse in the last month, obliged her to give up the gymnastic exercises she had previously enjoyed.

The appetite was voracious; but distension pain and nausea about two hours after meals had compelled her to suffer hunger rather than the pain produced by food; though at first the discomfort so long

after meals did not seem to be caused by what she had eaten. The bowels had been constipated since the pain began. Now she felt weak and depressed and had lost 11 lbs. in five months. Of this weight she regained 7 lbs. in four weeks, and with a well-fitting belt is quite free from local discomfort, the pain and constipation no longer troubling her.

CASE IV.—Mr. C., æt. 29. Complains of a dragging sensation in the back, with a feeling of always having a weight in his stomach, which is also the seat of a gnawing pain and flatulent distension. Immediately on taking food eructations arise, and two and a half hours after any food there are sour regurgitations. The stomach is enlarged and has fallen downwards to the left of the navel. There is obstinate constipation, inability to digest cellulose, acetic, and butyric acids have been found in the matters regurgitated. No vomiting has occurred. This condition of affairs came on suddenly one afternoon after a great shock. The appetite has been good throughout the two years since the difficulty in digestion arose; but he is losing weight, and is anæmic.

The first sound of the heart is feeble, and inaudible in the recumbent posture.

The diagram shows the position of the stomach in the recumbent and erect position.

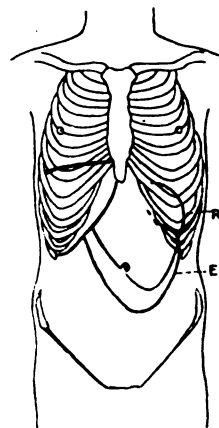


DIAGRAM V.

For the patient I ordered a belt, and saw him again last month, after the lapse of a few weeks, the physical signs and subjective symptoms of gastroptosis, and atonic enlargement are still present as before; but the patient has gained six lbs. in weight.

These four cases illustrate fairly well what may be regarded as conditions of difficult digestion due to displacement.

Cases I. and III. were treated by rest, uptilting diet and manipulation, a belt being worn since in order to maintain the organs by upholding the hypogastrium. The second case is still under treatment, and the fourth will probably need to have the abdominal pressure restored by the replacement of packing material and the improvement in quantity and quality of the abdominal muscles, for unless this is accomplished the ill effects of enteroptosis cannot be overcome.

WE are asked to announce the Committee of Management of the Royal Orthopædic Hospital have offered to place two wards (containing ten beds) at the disposal of the War Office for the reception and treatment of soldiers wounded in the South African campaign.

The Harben Lectures.

DIPHTHERIA.

By PROFESSOR WILLIAM R. SMITH, M.D., D.Sc.,
F.R.S.Ed., BARRISTER-AT-LAW,

ABSTRACT OF LECTURE II.

In the present day only such diseases are considered infective as are produced by a living organism entering the body from without, and capable of multiplication within. A disease caused by a substance not capable of multiplication within, such as a chemical body, is spoken of as an "intoxicative" process. In such infectious diseases as diphtheria, anthrax, or tetanus, we have a combination of these two causes—viz., the mechanical presence of a scientific organism, and the metabolic products of the life of such; indeed, the general rule of an infective process due to a vegetable micro-organism, is that the principal lesions are occasioned, not directly by the organisms, but indirectly by such organisms consequent upon the metabolic products of their growth.

Sometimes the organisms produce mechanical disturbances either locally or generally, which are likely to materially modify the symptoms caused by the toxins. The intoxication may be local or general, examples of which are found, of the one in some forms of suppuration, and of the other in diphtheria.

Closely associated with this aspect of the subject is the question of predisposition or susceptibility to disease. This may be either natural or acquired.

We know that animals possessing the power of resistance to the contraction of certain diseases may be rendered susceptible by the adoption of certain measures; e.g., pigeons and hens, which are naturally resistant to anthrax, can be rendered susceptible by starvation, whilst white rats do not in this way lose their immunity. The deprivation of water will also render dogs, hens, pigeons, and other animals susceptible to anthrax. Again, fatigue, loss of blood, an unsuitable diet, exposure to heat, cold, or damp, are also capable of removing the natural immunity of animals, and what is true of individuals is also true of races.

Age also is an important factor. I shall have to show presently that in diphtheria the child is more susceptible than the adult. Closely allied with the subject of predisposition and natural resistance or immunity is that of acquired immunity. If a person has suffered from an infectious disease, he is more or less protected against a second attack. In some cases the immunity is permanent, as with small-pox, whooping-cough, &c.; in others it is transient, as with diphtheria. In the laboratory immunity may be produced by inoculation either with an attenuated virus or small doses of living and fully virulent organisms, or thirdly, with the metabolic products or toxins of living bacteria. For this chemical vaccination either small doses of the virulent poison or of the attenuated toxins are used, and by repeated inoculation the animal is accustomed to withstand larger doses.

Further experiments on this most interesting subject resulted in the proposition established by Behring that, "if an animal has been artificially protected against a particular infective agent, its blood or serum acquires the power when injected into another animal of directly transmitting an immunity from that agent"; e.g., the blood serum of animals artificially protected against diphtheria has the power of protecting susceptible animals both from infection by the diphtheria bacillus and from its toxin. It was further shown by Behring that the protective serum can exert this marvellous power even after infection has taken place, when the symptoms of infection or intoxication have set in, and consequently such serum is not only protective, but curative. It is obvious, however, that in this latter case larger doses of the serum and promptness in its application are desirable. If immunity be obtained by injections of the bacilli or its toxins, it is only subsequent to a struggle on the part of the animal with the disease. On the

other hand, if serum be injected, the part played by the animal is a passive one, there being no struggle whilst the immunity-conferring substance circulates through its tissues. Thus we have, according to Ehrlich, active and passive immunity.

There are several points in connection with the etiology of diphtheria which we shall now do well to study. We find, for instance, that the disease is most prevalent in London in the latter half of the year, and particularly in the last four months. Another interesting fact in connection with the age incidence is that the two sexes are differently affected at the same age-periods by diphtheria. In the first year of life boys are much more liable than girls to die of the disease; but this extra liability diminishes year by year, and in the third or fourth year it is transferred to the female side. This is true both in London and in other parts of the country.

In London, however, the maximum male mortality is at age one, the female mortality steadily increasing for the next two years, whilst in the remainder of the country a maximum is reached for both sexes at age three. But London and the remainder of the country are alike in this, that more females than males die from diphtheria at age three, and many more in the age-group 5 to 10. It might be thought that these differences could be accounted for by the facts:—(1) That more males than females are born; and (2) that the general mortality among males is greater year by year than that among females. Thus the excess of male mortality in the earlier years might be accounted for by the larger number born, and the excess of female mortality in the later years by the larger number of survivors. Reference to the Census report shows, however, that this explanation is inadequate. After making due allowance for the different numbers of the two sexes living at each age, we find that in London the female mortality from diphtheria under one year of age is 86·8 per cent. of the mortality among an equal number of males at the same age. The percentage increases year by year, until at ages 2 and 3 the mortality of the two sexes is practically equal. After this the female mortality is in excess, being 30 per cent. more than the male mortality in the age-period 5 to 10. In the remainder of England and Wales the female mortality is only 77·6 per cent. of the male mortality under one year of age; but, as in London, the percentage increases year by year, except for a small irregularity at age 4, and the excess at age 5 to 10 is strongly marked, although it is not so great as in the case of London.

The age period 5 to 10 may be taken as very fairly representing school age; and any explanation of the incidence of diphtheria in London must deal with the fact that at this age girls are *one-third* more liable to die of diphtheria than are boys. It is hardly suggested by anyone that school aggregation increases the amount of diphtheria by so much as one-third; but here there is direct evidence of some influence or condition which either affects girls only, raising their diphtheria mortality by one-third, or else affects girls more than boys, raising the mortality of both, but raising that of girls enormously more than that of boys. No difference of the school conditions of the two sexes can be imagined which would yield even a plausible explanation. The cause must be sought among conditions affecting boys and girls in different ways or to a different extent, *outside* the schools.

It is interesting to notice that the same rule holds good when we consider notifications in London, the only difference being that the year of transference is in most cases a year earlier.

To test the incidence of diphtheria on children of various ages in London (apart from the mortality, which is compounded of the incidence and the case-mortality the latter of which may possibly vary largely at different ages) the actual notifications of the disease were ascertained for as many years as possible, in separate years of age up to 10 years, and for the ages 10 to 15 in one group. Unfortunately, the ages were so imperfectly returned in the years prior to 1892, as to make the figures useless for any purpose of comparison. In 1892, 1893, and 1894, however, the ages were stated in 95 per cent., 97 per

cent., and 98½ per cent. of the cases respectively, and since that time, 1895-98, they have each year been above 99 per cent. By assuming that the small residuum of unnoted ages in each year should be divided out in the same proportions as the stated ages, a very close approximation to the truth is obtained.

The next process was to estimate the number of children of each age living in London in each year. The number of children at each age between 5 and 10 was calculated by interpolation by the method of finite differences, and the corresponding numbers living in each year since 1891 were estimated on the assumptions: (1) That the increase of population has been at the same rate since 1891 as between the censuses of 1891 and 1896; and (2) that the proportion of children of each age in the total population has remained the same as at the Census of 1891.

The population and notifications thus ascertained were then placed side by side, and the number of notified attacks of diphtheria per 1,000 living at each age was calculated.

Statistics thus compiled show that the greatest attack rate is generally at age 4 to 5; the next that the attack rates are nearly equal for the 3 years of age 3 to 4, 4 to 5, and 5 to 6, and that on each side of this period of 3 years the rates fall considerably. A closer examination shows that infants under 1 year of age are remarkably exempt, their rates being on the average only about two-thirds of the rates for children between 10 and 15 years of age, and less than one-fifth of the rates at age 4 to 5. This exemption, however, appears to cease on completion of the first year of life. If the notification returns may be trusted, the liability to diphtheria is three times as great among children between 1 and 2 years of age, and four times as great among children between 2 and 3 years of age, as it is among infants in their first year. A possible explanation of this remarkable difference is that diphtheria is often spread by children sleeping together, and that young infants, by sleeping with their parents, escape this source of infection.

Direct infection from person to person is probably by far the most common cause of diphtheria, and it will be easy to understand that the presence of the organism in the throat of a discharged patient, or in an adult where but little trouble arises since his power of resistance is great, might under favourable conditions for transmission be a fruitful source of the disease.

Milk is undoubtedly a vehicle of diphtheria, and outbreaks of the disease have been frequently traced to this source; but the disease does not appear to have any direct relation to defective sanitary conditions, although such conditions may lower the general power of resistance, and give rise to throat complaints, which would provide a favourable soil for the bacillus to thrive upon if it should obtain access. In the same way dampness of the soil, or of houses might predispose to the disease.

But of all conditions which exert an influence upon the spread of the disease, that of school attendance is supposed by many to be by far the most powerful and far-reaching. Let us look into this a little more closely.

Whilst there are objections to receiving death-rates as evidence of the prevalence of a disease, yet these are the only figures on the subject available for purposes of comparison, with the exception of London, where, owing to the notification system, far more valuable evidence is obtained from a consideration of the actual number of cases of illness.

Moreover, in the case of Dresden, Leipzig, and Vienna, it is impossible to obtain the age-distribution of the inhabitants. Consequently, in order to make use of the figures supplied, it was necessary to assume that the age-distribution of each city was similar to that of London.

Taking the figures thus obtained for what they are worth, it will be seen that the period of life on which diphtheria falls most heavily is during the first few years, and in this respect the result tallies closely with the figures obtained by more reliable methods for London. The years of greatest mortality in Dresden are the second, third, and fourth; in Leipzig the second, third, fourth, and fifth; and in Vienna the second and third; while in none of these towns is education com-

pulsory till the sixth year, by which time the mortality has dropped considerably. Consequently, in spite of the assumption mentioned above, the above figures are probably not very far from the mark, and it can be safely asserted that in these towns at least the chief risk of infection occurs previous to the school age.

From Paris, Copenhagen, and Venice the returns are not so full, but in each case the age of maximum mortality is considerably earlier than the minimum age of compulsory school attendance.

The opinions regarding the influence of compulsory school attendance on the spread of diphtheria, which have been formed by the various authorities above enumerated, differ considerably in the different localities. On reading through their statements, however, the impression obtained is that the majority consider attendance at school to be an unimportant factor in the spread of the disease; that it undoubtedly plays a small part, but no greater than would occur wherever social intercourse can take place; and, more important still, that closure of schools and abolition of compulsory education would not stamp out the disease.

It has been stated by Mr. Shirley Murphy that "the diphtheria mortality at ages 3 to 10 years did not fall in 1871-80 in anything like the same degree as the diphtheria mortality at all ages"; that "this new departure is most notable in London"; that "it is suggestive of a fresh factor of diphtheria at ages 3 to 10 years becoming operative in the decennium 1871-80"; and that "as regards England and Wales and London in 1881-90, as compared with 1861-70, the special incidence on the age 3 to 10 years is practically maintained."

Now it may at once be freely admitted that if it were true to say—

(a) That children aged 3 to 10 years attend school, and children under 3 years do not;

(b) Further, that diphtheria has of late years increased among children aged 3 to 10 years, whilst children under 3 years of age have been comparatively exempt—

then undoubtedly there would be a very strong presumption that school attendance is the chief cause of the increased incidence of the disease. But are these statements correct? In order to test this, it is not enough to begin by grouping the facts under the ages 0 to 3 and 3 to 10; it is necessary to ascertain what is the age-grouping under on which each set of facts most naturally falls. For instance, if it were found that the age of school attendance practically begins at 4 years, and that the special liability to diphtheria begins at 2 years, there could be hardly a doubt that the two things are independent. In such a case, the age-grouping 0 to 3 and 3 to 10 would only suggest false conclusions.

The average number of children in London living at age 3 to 4 may be taken as about 143,000; so, obviously, a very small proportion of children at this age are subject to the risk of school infection, and it is more correct to speak of 4 years instead of 3 years as the age at which school attendance commences. We should, therefore, expect that any tendency to school infection would show itself in a marked manner at age 4.

If we consider the diphtheria notifications per 1,000 living at ages under 15, it is seen that the greatest number of attacks take place between the ages of 3 and 6, and that there is a marked drop after this age.

The same argument which has been used above in respect of the increase or decrease of diphtheria mortality at particular ages in successive periods of time is applicable to these notification rates, viz., if it can be said (1) that children above a certain age attend school, while those below that age do not; (2) that children above that age are specially subject to diphtheria, while those below it are comparatively exempt—then there will be a strong presumption that school attendance is the main factor in the spread of the disease.

Very slight scrutiny of the returns shows at once that the conditions just suggested do not exist. It is true that the notifications reach their maximum at ages 3 to 5, the first years in which any appreciable number of children attend school; but they reach the maximum, be it noted, by a steady yearly rise through the anti-school period of life.

At the age 4 to 5, although there are more than twice as many children attending school as between 3 and 4, yet the number of attacks is practically the same at the two periods; while from 5 to 6 the school-attending children are more than three-and-a-half times as numerous as at the age 3 to 4. That is to say, greatly increased numbers of children are subjected to the risks of school infection, and yet the number of attacks is either the same or shows a decline.

Moreover, we find that the attacks at age 1 to 2 were nearly three times as many as in the first year of life. At age 2 to 3 they were 31.5 per cent. more than at age 1 to 2; and at age 3 to 4 they were 26.4 per cent. more than at age 2 to 3. Thus the *proportional increase* was less in the first year of nominal school life than in the year immediately preceding it. In the next year of age—4 to 5 years—an increase of 129 per cent. in the children attending school is accompanied by an increase of only .3 per cent. in the diphtheria attacks; and at the age 5 to 6 a further increase of 55.7 per cent. in the children attending school is accompanied by a decrease of 6.5 per cent. in the diphtheria attacks.

Stronger evidence could hardly be adduced that age-susceptibility is the main factor in the selection of the victims of diphtheria, and that, at the most, school aggregation acts only as a slightly disturbing element. It appears reasonable to suppose that if there were no school attendance at all, the increase of attacks at age 3 to 4 over age 2 to 3 might be somewhat less than 26 per cent., and that the decrease in subsequent years might be somewhat more rapid than it actually is. But this is only another way of saying that diphtheria is sometimes communicated at school; the age-incidence would probably be altered to a much greater extent if children were prevented from playing together out of school. Such suggestions are, however, entirely hypothetical. But it is a fact that a child becomes *more* liable to be attacked by diphtheria year by year as it approaches school age, and becomes *less* liable year by year after it has reached school age.

From the facts represented in these diagrams it is impossible to resist the conclusion that no *special increase of liability* to diphtheria can be traced to the beginning of school attendance. In fact, the ages which are now the most subject to the disease would still be the most subject if aggregation in schools were abolished altogether.

Taking the notifications at each age, for the four weeks preceding the holidays in 1895, i.e., the four weeks ending August 3rd—for school-influence would naturally be manifested for some days after the closure of the school—and comparing them with the notifications during the four weeks of holiday, i.e., the four weeks ending August 31st, and also with those of the four weeks after the holiday, i.e., the four weeks ending September 28th, we get the following table:—

Notifications in London at each age for the four weeks before, during, and after the holidays in August 1895.

Four weeks ending—	0	1	2	3	4	5	6	7
August 3 ...	33	66	82	116	119	103	81	65
August 31 ...	18	59	59	74	71	57	62	39
September 28	25	56	73	114	109	86	92	71
	8	9	10	11	12	13 to 15	15 and upwards	
August 3 ...	54	48	34	20	30	48	228	
August 31 ...	30	31	31	19	13	35	201	
September 28	46	39	44	23	24	40	233	

It is at once apparent that the drop in the notifications is almost as marked at the ages below school-age as at school-ages, and is also well marked at ages above school-age. The recrudescence after the holidays is also seen in the three groups of ages, though here the increase is most marked in children of school-age.

I am at a loss to understand, if school influence plays the predominant part suggested, why we do not get a

greater incidence of the disease during the many weeks the schools are in session, and when for the most part the curve is below the mean; and I confess I should be inclined to attach greater weight to the coincidences if year by year we found a fall occurring with regularity in the first holiday week, and being maintained throughout the holidays; but this is by no means the case.

The falls during the holiday periods may be accounted for by the smaller number of children at these times in London, and perhaps more fully by the removal of the supervision which is exercised by a staff of some 10,000 teachers during school periods.

It may be, and frequently is, necessary that the school should at this time be visited by a skilled medical man for the purpose of examining into any condition which may suggest itself, including the examination of the children, and the Board are considering at this moment whether any further effective arrangements can be made in this respect.

From a study of this evidence, it may be necessary to close a department or a class-room, in which case the committee concerned is so advised; or the disinfection of one or more rooms may be desirable, when the assistance of the Local Sanitary Authority is solicited. In any case a copy of the return and all the facts of the case are brought under the notice of the Medical Officer of Health interested, and a conference by telephone or otherwise obtained.

Further, if any children in attendance at school show symptoms of an infectious disease, they are at once to be excluded, and intimation given both to the Medical Officer of Health and to the medical officer of the Board; and for this purpose the teachers are instructed in the various symptoms of the different infectious diseases.

Clinical Records.

TABETIC OPHTHALMOPLÉGIA. (a)

Under the care of Dr. LEONARD GUTHRIE.

This patient, a postman, æt. 65, seven months ago suddenly developed ptosis of the left eyelid with crossed diplopia and external strabismus. For twelve months he suffered from weakness and unsteadiness of gait, giddiness, and tremors of head and right arm. Two years ago he had some kind of fit attended by momentary loss of consciousness, but no similar attack had occurred since. He had had a chancre, followed by non-suppurating bubo and severe sore throat at the age of 24. He had been six months under observation, during which time the symptoms became less marked, but the left eyeball deviated outwards as before, and could not be moved upwards nor inwards beyond the mid-line. Quite recently, the right eyeball also could not be moved inwards beyond the mid-line, nor upwards, but its movements outwards and downwards were unimpaired.

The pupils were moderately contracted and reacted little, if at all, to light. Accommodation could not be tested owing to loss of convergence. The knee-jerks, present six months' ago, had gradually disappeared. His gait had become more ataxic, and Romberg's symptom was now manifest. Sensation was unaffected except that the ulnar nerves behind the inner condyles were abnormally insensitive. He had some difficulty in holding his water. No "lightning pains." Dr. Guthrie considered that the diagnosis of tabes was now obvious, although six months previously the presence of tremors, and the absence of any definite signs of the disease, including that of "lightning pains" had created doubt as to the nature of the case. He drew attention to the frequent occurrence of paralysis of ocular muscles as pre-ataxic symptoms. Such cases of ocular paralysis usually came under the notice of ophthalmic surgeons, and were frequently cured, or the paralysis spontaneously subsided, perhaps years before other signs of tabes appeared.

(a) Notes read before the Harveian Society of London, January 4th, 1900.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON
MEETING HELD FRIDAY, JANUARY 12TH, 1900.SIR R. DOUGLAS POWELL, Bt., President, in the Chair.
CLINICAL EVENING.

COMPLETE SUBPERIOSTEAL RESECTION OF OS CALCIS.

MR. J. HUTCHINSON, jun., showed a young man, *æt.* 17, on whom he had performed complete subperiosteal resection of the os calcis for osteo-myelitis with excellent results, in that the patient was able to walk and bear his weight upon the reformed bone. The only drawback was some retraction of the great toe.

MR. HERBERT PAGE remarked that the operation was by no means a novel one, his father having done it as far back as 1840.

MR. HUTCHINSON, in reply, repudiated any claim to originality, observing that though not new the operation was sufficiently rare to make it of interest in view of the result.

PAROXYSMAL HÆMOGLOBINURIA IN A CHILD.

MR. LUNN showed a girl, *æt.* 6, the tenth of twenty-four children, of whom fourteen were living, in whom the peculiarity was noticed when one year of age. From time to time she passed port wine urine containing normal red cells. The proportion of red corpuscles to white in the blood was about half normal. Her sister was suffering from interstitial keratitis, which pointed to syphilis.

MR. LUNN also showed a child, *æt.* 5, with congenital luxation of the right hip, also a man and a woman suffering from double facial diplegia.

MR. W. G. SPENCER recalled a case he had shown of a boy with paroxysmal hæmoglobinuria, who had had several attacks of dry gangrene, the first attack dating from his sleeping out one summer's night. The case, he said, was obscure, but Professor Osler had noted cases of Raynaud's disease with high arterial tension associated with, apparently, congenitally thickened arteries. Many such cases ended early in life by uræmia or apoplexy.

MR. J. JACKSON CLARKE asked what treatment the author had adopted, or proposed to adopt, in the luxation case. He observed that it was one of the slighter degrees of congenital dislocation, therefore, not one urgently calling for treatment. He called attention to the limitation of abduction in these cases, and suggested resort to Lorenzi's bloodless method.

DR. VOELCKER commented on the interest of the evidence of syphilis in the connection with hæmoglobinuria, adding, that in a large proportion of these cases there was a definite history of inherited syphilis. In one case, to which he referred, there was a history of acquired syphilis. On examining the blood, he had noted an undue tendency of the red corpuscles to cohesion, forming snake-like coils and the corpuscles were elongated or lemon-shaped.

DR. SUTHERLAND recalled that paroxysmal albuminuria and hæmoglobinuria had been described as alternating manifestations of the same condition. Another condition often present in these cases was an excess of oxalates, this excess persisting for a considerable time after the hæmoglobinuria had passed off.

MR. LUNN said that he had not adopted any treatment in the luxation case fearing to make matters worse than they were. The hæmoglobinuric patient usually got a rise of temperature with chill and collapse when the attack was imminent, but in the intervals her health was good. They had suspected heightened tension. Oxalates had been found in the urine, but the intermediate urine appeared to be normal.

MALIGNANT DISEASE OF THYROID AFTER TWO OPERATIONS.

MR. CHARTERS SYMONS showed a woman, *æt.* 58, who came in September, 1897, with a growth in the left lobe of the thyroid. The enlargement had been noted nine years before but had remained stationary until 18 months previously. When he saw her there was a large fixed swelling pushing the windpipe over to

the right and causing a good deal of dyspnoea. He removed a large portion of the growth and then performed tracheotomy in November, 1897. In the spring of 1899 the pressure returned and he then extirpated the whole of the left, and the major portion of the central lobe of the gland leaving only a portion too deep behind the sternum for safe removal. The operation was almost bloodless. She had paralysis of the left vocal cord but could speak distinctly. There was no longer any discomfort. He called attention to the comparatively small amount of blood lost, as was usual with purely epithelial growths of the gland, and he insisted on the peculiarity of the growth remaining unilateral, and on the supervention of malignancy on long standing enlargement of the gland.

MR. A. BARKER remarked on the fact that malignant growths of the thyroid often ran a very chronic course, a peculiarity which he thought was characteristic of malignant growths in this situation, and he alluded to a case of his own which had lasted 18 years, 12 of them under his own observation.

MR. SYMONS, in reply, said that in one of his cases the history extended over ten years but in another only twelve months.

EXCISION OF THE NECK OF THE LOWER JAW FOR ANKYLOSIS.

MR. JACKSON CLARKE showed a girl, *æt.* 8, who had had complete fixation of the lower jaw for upwards of three years. He cut down over the right temporo-maxillary joint through an incision planned to avoid the trunk of the facial nerve, the parotid duct, the superficial temporal artery, &c., and removed the neck of the bone. The result of the operation was entirely satisfactory, and after a few days the patient could masticate food and promptly gained in weight. She could now open the mouth more than an inch and close it perfectly. He referred to another case in which he had performed similar operations on both sides for bilateral ankylosis with equally good results.

MR. BARKER observed that it used to be taught that such operations were useless because the condition was sure to recur, probably because the wounds did not heal aseptically. He asked whether some interference with growth affecting the symmetry of the face was not to be apprehended after these operations.

ARTHRECTOMY OF KNEE FOR TUBERCULOUS DISEASE.

MR. F. EVE showed a girl, *æt.* 13, who had come with tuberculosis of the knee. Treated in the usual way no improvement followed, so he performed arthrectomy through an incision over the patella, which was divided, the capsule being opened by lateral incisions, taking care to spare the lateral ligaments. The semilunar cartilages were removed, and one crucial ligament had to be cut through but was afterwards refixed to the bone. The lower end of the internal condyle was ulcerated, and had to be scraped, and the capsule was then carefully sewn up, union running an aseptic course. There was actually very free movement, almost to a right angle.

MR. BARKER expressed the hope that such a case as this might become the rule instead of being the exception.

MR. SYMONS recalled a case of his own in which he had performed a similar operation six years ago, but the patient had recently complained of pain.

MR. HUTCHINSON, junr. said that in two cases of arthrectomy he had got 30 degs. of flexion, but still not as good a result as in this case. He remarked that in cases of extensive disease it might be risky to try to obtain this result instead of contenting themselves with obtaining a perfectly stiff limb.

MR. JACKSON CLARKE said he had never seen such a good result. He himself usually applied Thomas's splint with results, on the whole, encouraging. If one could choose one's cases arthrectomy might, however, be the operation to be preferred.

MR. EVE, in reply, said he hoped to show the patient again at some future date. He admitted that the case was from the first distinctly of a subacute nature. Where there was much caseation and ulceration he would not attempt it.

RESECTION OF RADIUS FOR SARCOMA.

Mr. EVI also showed a young woman who, after an injury developed a tumour presenting the symptoms of myeloid sarcoma of the radius. In March, 1897, he removed the lower thirds of the radius and ulna. The tumour was encapsuled in bone. He shortened all the flexor tendons except the flexor carpi radialis. He defended the removal of the lower portion of the ulna, on the ground that otherwise the hand would ultimately have assumed a position at right angles to the limb. When, however, the ulna was the bone involved it might not be necessary to remove the radius. There was very good movement of the hand, and the patient could even write.

A CASE OF HEREDITARY ATAXIA.

Dr. VOELCKER showed a small boy, *æt.* 12, under observation for four years. After an attack of German measles (?) at 5 he developed trembling which was diagnosed as chorea. He was brought to the hospital in 1896 on account of unsteadiness of gait, which increased when the eyes were closed, and the knee-jerk was absent. Recently sight had begun to fail, and Mr. Gunn had reported that there was well-marked retino-choroiditis with atrophy of the nerves and sclerosis of the retina, changes which were regarded as syphilitic. There was no disturbance of sensation or involvement of the sphincters. No muscular wasting, but some amount of lateral curvature of the spine. He had been treated with iodides, but without benefit.

Mr. HUTCHINSON, junr., asked whether the ocular changes *per se* could be taken to justify the diagnosis of syphilis.

Dr. VOELCKER, in reply, read Mr. Gunn's report, but admitted that he had failed to discover any other evidence of congenital syphilis.

Mr. SHAW showed a man, *æt.* 40, who, after an injury to the wrist ten years ago, followed by formation of abscesses, had developed a curious condition of the hand, which was swollen, livid, very tender, and painful, the condition tending to spread up the arm. The hand was cold and movement was greatly impaired. He remarked that it might be a case of lymphatic oedema or erythromelalgia.

EXCISION OF TONGUE FOR MALIGNANT GROWTH.

Mr. BARKER showed an elderly man, whose tongue he had removed five years ago for epithelioma, without recurrence.

Mr. BARKER also showed a man (with skiagram) who sustained a slight blow to the knee on the ice. On examination no special injury could be detected, but he took the precaution to cause a skiagram to be made, whereupon a very distinct fracture of the patella was evident. Even with that knowledge, however, it was difficult to detect.

HARVEIAN SOCIETY OF LONDON.

MEETING HELD THURSDAY, JANUARY 4TH, 1900.

H. E. JULES, F.R.C.S., President, in the Chair.

ORBITAL EXOSTOSIS.

THE PRESIDENT showed a young woman, first seen in 1892, with a small hard nodular mass at the inner angle of the left orbit fixed to the nasal process, blocking the nasal duct, causing a mucocele, and the lower canaliculus was slit up. He discussed the desirability of removing the tumour.

Mr. ROUGHTON advised the removal of the tumour, and thought the best instrument for the purpose would be the surgical engine.

COCCYGEAL TERATOMA.

Mr. FRANCIS JAFFREY showed a large tumour removed from the coccygeal region of a female infant, *æt.* 6 months, partly fluid and partly solid, which on

closer examination proved to be a case of teratoma. The tumour had increased in size after admission. It had been tapped twice, and some fluid like turbid beer removed; this fluid was evidently not cerebro-spinal in origin, nor did it correspond to amniotic fluid. The cyst in question had probably arisen in the usual manner, viz., as representative of an attempt at another embryo.

Mr. RAYMOND JOHNSON thought the tumour was probably one of the more common multilocular cystic tumours occurring in this region. The tumour probably extended up between the sacrum and rectum, and its removal would involve a more extensive operation than the child could at present stand.

DEFORMITY OF ARM.

Mr. HUBERT PHILLIPS showed a youth, aged 17 years, with considerable shortening of the humerus, what appeared to be the upper extremity of that bone projecting on the inner side of the arm when the biceps were called into action. Curiously enough, nothing abnormal was noticed until the patient fractured his right arm about nine years ago. He considered that surgical interference was not only not called for, but would be absolutely injurious, as the arm was a most useful one in every way.

Mr. ROUGHTON and Mr. JACKSON CLARKE regarded the deformity as the result of a fracture of the upper part of the shaft of the humerus which had united at an acute angle.

Mr. JACKSON CLARKE showed a male patient, *æt.* 37, who sustained a severe compound and comminuted fracture of both bones of the left leg in July last. A fragment of the tibia measuring over 3 ins. had to be removed because it was quite separated from its periosteal and other connections, and it was contaminated by dirt from the roadway being ground into it. The two remaining segments of the tibia were approximated and fixed by silver wire, and recovery was uninterrupted. The patient has now a useful limb in which 3 ins. of shortening is compensated for by a raised boot.

SYPHILITIC DISEASE OF BRAIN.

Dr. JAMES TAYLOR showed two cases illustrating the result of anti-syphilitic treatment in syphilitic disease of the brain. The first case was that of a woman whom he had brought before the Society eighteen months previously and who at that time had right-sided hemiplegia following typical Jacksonian epilepsy. The patient had been treated with iodide of potassium and mercury with complete success. The second case was that of a man who was at first believed to be suffering from ordinary epilepsy. The attacks were, however, followed by left-sided hemiplegia, headache, and optic neuritis. Iodide of potassium was given internally, combined with inunction of mercurial ointment. After a considerable time the fits ceased, and the other symptoms improved, but recurred with cessation of the treatment. The latter was resumed, and now the patient only presented a very slight degree of weakness, especially in the left leg, and occasional faint attacks.

Dr. LEONARD GUTHRIE read notes of a case of "Tabetic Ophthalmoplegia," which will be found under "Clinical Records."

The PRESIDENT and Dr. JAMES TAYLOR discussed the case, and agreed upon the frequency of ocular paralysis in the early stages of tabes. Dr. Taylor had seen a number of such cases at the London Ophthalmic Hospital, and had usually found the knee-jerks still present. The paralysis was usually transitory, but it might be permanent, and was then probably due to nuclear changes.

CONGENITAL DISLOCATION OF HIP.

Mr. ROUGHTON showed a man of 20, who exhibited the characteristic appearances of a bilateral dislocation.

Mr. JACKSON CLARKE remarked upon the favourable results which had been obtained in the treatment of this deformity in early life by Lorenz's bloodless method.

Dr. SUTHERLAND and Dr. TAYLOR also spoke, and Mr. ROUGHTON replied.

BRADFORD MEDICO-CHIRURGICAL SOCIETY.
MEETING HELD DECEMBER 19TH, 1899.

The President, Mr. W. HORROCKS, F.R.C.S., in the Chair.

Dr. KERR showed a case of extensive wound of the eyeball extending through the ciliary region. There had been sympathetic irritation of the opposite eye, but this had subsided, leaving good vision. The injured eye had not been removed, but the prolapsed iris was snipped off and the lids washed out immediately after the accident.

Dr. EURICH showed a series of microscopic sections illustrating the commoner diseases of the breast.

Dr. HIME showed a specimen of the bacillus of bubonic plague.

Dr. ALTHORP showed a patient who had been treated by laparotomy when suffering from tuberculous peritonitis. The patient was in good health.

CONTAGION IN MODERN TIMES.

Dr. SMALL read a paper on contagion in modern times. (The paper was a continuation of one previously communicated to the Society, on the Ancient Ideas of Contagion.)

In the Middle Ages many diseases were considered contagious, but some of them were also traced to other causes. Epidemics, for instance to poisoned air, which idea did not tend to promote ventilation; to putrefaction from internal causes, what we now sometimes call auto-infection; to the influence of stars, planets, eclipses, earthquakes and volcanoes; to famine or too great plenty and to supernatural beings. Sometimes there was a strange mixture of natural and supernatural causes. There was little attempt to define the influence of the various agencies. Diseases were equally indefinite, but Rhazes, in his description of small-pox and measles had introduced the specific element which ultimately altered the whole aspect of the matter. Leprosy was a prominent example of contagious disease, but it diminished in importance after the epidemic of syphilis at the end of the fifteenth century. No doubt the two had often been confounded. The great plague of 1384, since known as the Black Death, drew much attention to the subject of contagion. Many fevers that we should now call typhus, and consider contagious, were then looked upon as caused by chills or other causes. Small-pox was by no means thought to be infectious at all times and places, and even plague was doubtful to some authorities. What appears to us an extreme reluctance to admit contagion was sometimes shown, some preferring to attribute a large mortality to fear alone. In this matter there have always been sceptics, their minds continually asking "how?" and "why?" not being satisfied with mere contact as a cause in the absence of some far-reaching theory to explain the *modus operandi* of contagion.

Mr. BASIL HALL read a paper on "Tuberculous Disease of the Great Trochanter," and gave reports of three cases."

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, January 14th, 1900.

ANGINA PECTORIS.

At the Medical Society a member spoke on the treatment of angina pectoris, which he considered should attract the attention of every medical practitioner more particularly as he can render considerable service in this affection. The treatment was twofold, that of the attack and that of the interval between the attacks.

Above all the patient should be enjoined absolute rest. The windows of the room should be opened to procure as much pure air as possible. Mustard to the legs, neck, and præcordial region, so frequently employed by persons in attendance on the patient, should be discarded; it did no good and only wasted time. Injection

of morphia on the other hand was a good means of treatment; open, however, to the objection that if it were necessary to use them often, there was danger of intoxication or of accustoming the patient to the drug, producing finally morphia-mania. Chloral was too slow in its action to be employed at the moment of the attack, and in any case it had a toxic effect on weak hearts. The same might be said of chloroform and ether by inhalation.

Iodide of ethyl and iodide of amyl, on the contrary, gave good results, but nitrite of amyl, in doses of from 18 to 20 drops on a handkerchief, should be preferred. Certain patients derive great benefit from nitro-glycerine, that is to say, those whose faces are congested, but with those who become pale during the attack and cadaverous looking it does not succeed so well. Hydrobromate of quinine, given at the outset of the attack, prolongs the action of the nitro-glycerine. Other remedies have been recommended for angina pectoris such as pyridine, cigarettes of stramonium, lobelia, &c, but they are only of value when attacks of asthma coincide with the angina, or in cases of pseudo-angina pectoris provoked by acute aortitis, neuritis of the cardiac plexus, pericarditis, or Bright's disease.

Once the attack has terminated the medical attendant should apply himself to prevent a return, or to diminish its frequency and intensity. To reach that result it was necessary to treat the malady of which the angina was a symptom. From what is known up to the present on the subject true angina pectoris is the result of sclerosis of the coronary arteries produced by chronic arteritis.

Iodide of potassium is the best agent in such cases; it should be given for months, if not years, at small doses (5 to 15 grains daily). The greatest perseverance is necessary, but to avoid iodism the treatment may be suspended ten days a month. In following that treatment the patient was almost sure to obtain very good results, and some had completely recovered. Instead of iodide of potassium, iodide of sodium, or strontium, or lithium might be given, but they are inferior to iodide of potassium.

During fifteen days every month the nitro-glycerine may be given to advantage; it dilates the vessels, and favours the circulation through the coronary arteries and their branches, facilitating thus the nutrition of the heart. Igni-puncture over the heart often renders good service, but if the patient objected to it, tincture of iodine might be used instead. As to abdominal massage recommended some time ago, it had not given any result in the speaker's practice.

The régime of the patients should be that of patient suffering from a grave heart affection:—Moderation at table, suppression of alcohol and tobacco, avoid moral emotions, muscular efforts, fatigue, dwell in a mild climate.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, January 13th, 1900.

At the Medical Society Hr. Gottschalk showed a NECROTIC PIECE OF PUERPERAL UTERINE WALL, with microscopic preparations. The portion was cast off along with foul-smelling discharge 18 days after delivery. On November 13th the speaker was called to

a primipara who had been three days in labour. The liquor amnii had escaped four days before. The pains were strong, the head not yet engaged. The patient was small, with a universally contracted pelvis, the conjugate about 9 ctm. The head at the inlet pressed on the swollen lip of the womb. The abdomen was very pendulous, the uterus firmly contracted. All the conditions for rupture of the uterus were therefore present. Forceps were tried under chloroform without effect; turning was then performed, a living child being extracted. The uterus contracted well, and the placenta was expressed. The pulse continued high, and two days afterwards strong rigors took place, with quick rise of temperature to 40 degs. C. On seeing the patient four days afterwards he found high fever. Pulse 130, abdomen considerably distended, painful. The discharge was sweet, since delivery, no sleep. The uterus was washed out with a litre and a half of a 1 per cent lysol solution, and afterwards 1½ litres of a 60 per cent. solution of alcohol. The condition went on getting worse to the sixth day. The pulse could not then be felt. A camphor injection did not improve matters, and as the condition was the same the next day a supra-clavicular saline infusion of one litre was made, followed by a striking improvement, and the patient slept. The pulse, however, still remained so quick that digitalis and strophanthus had to be given. The discharge became foetid on the fifteenth day, and on the eighteenth a portion of mucous membrane came away which was saturated with cocci, in the lymph tracts, and veins, along with numerous thrombi. The patient recovered. With regard to washing out with alcohol, absolute alcohol acted as a caustic, but a 60 per cent. solution did not. This only acted by extracting water, and contracted and irritated vessels. In the future he would not place much reliance on it, but, on the other hand, the saline solution he could recommend as a life-saving measure. This view had been since confirmed in a later observation. He looked upon the case as one of partial gangrene of the uterus.

Hr. Kirchner followed with a paper on

LEPER HOUSES—PAST AND PRESENT,

in which he gave a history of these institutions from the first, founded in 564 by Gregory of Tours. In the twelfth and thirteenth centuries there were 2,000 of these houses in France alone; every large village had one, generally named after some saint. The leper houses were the predecessors of hospitals. After leprosy had been extinguished for centuries it was observed in some parts of Russia, and especially in 1832, 1842, and 1850, and houses were established for the reception of cases. In Norway fresh advances had been made in the treatment of the disease by Armaner Hansen, and model leper houses were established in several towns. The disease was comparatively rife in Russia; 1,600 cases were officially notified, but probably 5,000 would be nearer the number. The speaker then went on to describe the relation of the disease to Germany and the measures taken to arrest its spread, and said that with the aid of leper houses and prophylactic measures the chronic diseases would be extinguished.

Hr. Virchow said that leprosy had never spread epidemically, but only partially, and in certain localities, but that there it had decimated the population. He was convinced that leprosy had never extended like syphilis did after

its first introduction to Europe; even after the Crusades its extension had never been so great. It had never been so prevalent and so infectious as the laity had represented. This erroneous idea of the laity had often been taken up by medical men. Even now diagnosis was not easy if the case was not of the tuberculous form. He held to the traditional view of the identity of "Zaraath" with leprosy. It was certain that many cases of other skin diseases had at times been classed under leprosy, as had been the case formerly with regard to syphilis. The Holy Ghost hospitals were not to be placed in the same category with the St. George's hospitals; only the latter served for the reception of lepers, and were located *extra muros* (as in Berlin the St. Jürgenhaus was situated in front of the Königsthor whilst the Holy Ghost hospital was *intra muros*, and was used for all diseases). Kirchner's view of the connection between the present city hospitals and the old lazarettos was not quite correct. The upward movement of modern hospitals dated from the time when they passed into the hands of the community, and were withdrawn from the religious bodies. There would never be any epidemic of leprosy—any fear of this kind might be absolutely excluded—neither could there be any compulsory separation of such patients. He, the speaker, saw and examined every year a considerable number of leprosy cases coming from foreign countries which were not known to the police, and which remained here without restraint and had never given rise to contagion. The measure taken in Memel would, therefore, be enough to prevent further extension.

Hr. Blaschko said that the mode of infection was very enigmatical. He had heard of cases where a couple had been married forty years without the husband infecting his healthy wife, and of others where fourteen days had sufficed to infect. It was necessary to keep a watch over the Russian borders particularly in certain districts, and to favour voluntary visiting of hospitals so that the inmates should not be cut off from the whole world, and to support on the part of the State those dependent on patients who had entered hospitals.

Hr. Korte said that at the Cape of Good Hope, the spread of the disease had almost reached the dimensions of an epidemic. At present the numbers reached 6,000 to 8,000. In a limited territory, where in 1870 lepra was unknown, an inquiry made in 1886, shortly before his departure from the district, showed no less than 900 cases. These facts showed the importance of an energetic watchfulness with regard to the disease in tropical and sub-tropical regions.

Hr. Kirchner, in reply, said there were insurmountable financial difficulties in the way of government support of the dependents of the inmates of leprosy houses. As much might be expected for the dependents of tuberculous cases in hospital. On account of the peculiar manner of the spread of the disease, prophylactic measures should not be given up. Urbanowitz had ascertained that two elderly ladies in poor circumstances had been infected by a seamstress, quite a number of families by a beggar, others by a maid servant, &c. From Koch's investigations it was known that in some cases of apparently nerve leprosy the nodules in the nasal mucous membrane gave off a mass of bacilli; whether these were capable of setting up infection was not known.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, January 13th, 1900.

RENAL DISPLACEMENT.

At the Gesellschaft der Aertze, Hochenegg showed a malformed kidney which he had removed as a tumour from the left side of a female patient. The history of the tumour pointed to a congenital origin, and, after careful examination, it was concluded to be an "Intra-ligamentous Myoma." As the swelling had been the cause of much worry and bodily discomfort, it was decided to remove the tumour *per vaginam*, as by this means it would be extra-peritoneal. For twenty years, in addition to the psychical depression which had led her several times to attempt suicide, she suffered from intractable constipation.

Hochenegg operated by the sacral method, but on reaching the tumour he was surprised at the amount of fat and large vessels leading into it. Closer inspection revealed a triangular small kidney, with the hilus in front, its vessels proceeding from the iliaca communis.

After the operation she soon recovered, the constipation disappeared, as well as the psychical disturbance, while the urinary secretion became normal, both in quality and quantity.

Kundrat recorded his experience of these congenital abnormalities. He had met with them both bilateral and unilateral. When unilateral the left side is a most frequent seat, and their position varies, though the pelvic cavity is a frequent site. He has met with them in the peritoneal cavity both unilateral and bilateral as well as crossed, that is, the left kidney in the right side of the body, while the right occupied the left, which may be termed crossed dystopia. These displacements are usually associated with other malformations such as deficiency of the organ itself, or of the ovaries and tubes. Atresia is also a frequent complication.

The clinical importance of dystopia may be arranged in three classes:—(a) Does this displacement produce nephritis, hydro-pyonephrosis, calculous formation, or other diseases? According to Strube these diseases are met with more frequently under these circumstances than in the normal position, although he admits that anuria is not uncommon from compression of the ureters. (b) The obstruction to labour and fæcal discharge as in Hochenegg's case. Cases of this kind are recorded in which the kidney has been expelled from the vagina during labour. (c) The severe nervous symptoms which are extreme and protracted.

The diagnosis is usually confirmed by operation, and is more difficult in the male, being confounded with sarcoma of a cryptic testicle, periproctal abscess, and tuberculous glands; in the female with myoma, ovarian and other tumours.

A PORTABLE OPHTHALMOSCOPIC DARK ROOM.

At the Medical Club Bundi showed a very ingenious apparatus which formed a dark room for examining the eye with the ophthalmoscope in the open sunshine.

The arrangement is formed of an extensible frame, on which is stretched black cloth, and which envelops the heads of both operator and patient. A small electric light is attached by means of a hoop to the front of the

patient's head, whereby the operator can examine the eye either directly or indirectly.

The whole apparatus can be folded up like an umbrella.

ATAXIA TREATMENT.

At the "Doctoren Collegium" Bum introduced the subject of spinal ataxia and its treatment by compensatory movements. He quoted from Frenkel in 1890, who affirmed that the ataxic movements can be restored to the normal condition by repeated exercise. Leyden extended this doctrine and attempted to prove that the sight could be made to supplement the musculo-articular sensibility. Another theory was advanced that the sensory ataxia, by which co-ordinated movements were performed, depended on the integrity of the sensory sphere. From this it was inferred that such exercise treatment did not improve the sensibility, as the regulation of the central apparatus was the primary demand.

Bum was of opinion that the innervation of the antagonistic force was at fault, and was in favour of treating it by resisting movements. In conclusion he attempted to classify suitable cases for such treatment, and said it was not the degree of inco-ordination, but the character of the case that should determine the prognosis.

In rapidly developed cases or during the exacerbation period of moderate cases the exercise treatment is injurious. Old well-nourished, inactive cases improve rapidly by this treatment, but if amaurosis, malnutrition or psychical disturbance were present, such treatment should be abandoned. In the discussion that followed Roth recommended every ataxic patient to be examined ophthalmoscopically, and if atrophy of the optic nerve, diplopia, &c., were present, exercise should be prohibited. Winkler said that many ataxic patients were advised to practise this exercise-treatment at home without any dosage being prescribed, whereby more harm was done than good. He could hardly accept the exclusion of active and passive gymnastics, as many of our old brethren have applied the electric treatment with marked success which might yet be proved to be valuable in many of these cases. Haudek was of opinion that the prognosis depended very much on the muscular system and general nutrition. He was inclined to the treatment with baths of tepid water or, what he thought better, carbonic acid baths.

Scheimpflug reminded the members present that it was possible even in amaurotic ataxics to practise the exercise treatment where the tactile impressions could be educated. Bum replied that blind ataxics could not be so treated because the feeling was so much impaired.

The Operating Theatres.

MIDDLESEX HOSPITAL.

GASTRO-JEJUNOSTOMY.—Mr. JOHN MURRAY operated on a girl, æt. 19, for pyloric obstruction. She had been admitted six weeks before operation under the care of Dr. Pasteur, suffering from vomiting of ten months duration, coming on immediately after taking solid food and accompanied by pain in the epigastrium. The patient was pale, anæmic, and markedly emaciated. At the tip of the ninth costal cartilage on the right side was felt a raised, hard, nodular tumour. It measured two inches transversely, but its upper limit could not be defined..

It extended two inches below the costal margin. It was tender and moved slightly with respiration. The stomach resonance was obtained over a large area, and the organ was evidently dilated; there was no enlargement of the liver or of the spleen. During the period the girl was under observation in the hospital she vomited frequently, sometimes as much as five pints at a time; the vomit was very offensive, and contained large numbers of sarcinae; the diagnosis made was pyloric obstruction, the cause of which was doubtful. An operation was undertaken for the purpose of exploration and also for relieving the condition. The stomach having been washed out, the patient was placed on the operating table and lying on a hot water bed. The abdomen was opened in the middle line by an incision from the ensiform cartilage to half an inch above the umbilicus; this revealed a large and apparently malignant mass involving the pylorus and the pyloric end of the stomach, and extending to a considerable extent along the lesser curvature. The tumour was fixed posteriorly in the situation of the pylorus; several hard lumps were felt in the lesser omentum which were probably enlarged glands. Removal of the mass being impossible, it was decided to perform gastro-jejunostomy. The stomach was drawn out of the wound and a spot chosen on the anterior wall just above the greater curvature and as far over to the left as possible; the jejunum was next found and brought round to the left border of the transverse meso-colon, and a part selected about ten inches from its commencement, this was brought into apposition with the spot chosen on the anterior wall of the stomach; sponges were completely packed around each viscus so as to avoid soiling the peritoneal cavity, and the surfaces of the stomach and jejunum united posteriorly by a row of Halsted's sutures, these were tied and the ends cut short; the posterior row of sutures being also carried round, so as to approximate the surfaces laterally; then a similar row of sutures was introduced anteriorly. An incision an inch long was next made between the two rows of sutures, both into the stomach and into the jejunum. A little gas escaped from the stomach on its being incised, but no fluid or solid matter. The edges of the incision of the stomach were united by a few points of interrupted suture to the corresponding point of the cut surfaces of the jejunum the anterior row of sutures were then tied. The peritoneum was wiped over with sponges and the external wound united by three layers of sutures after the parts operated on had been dropped back into the peritoneal cavity. Mr. Murray remarked that the operation was undertaken first of all for the purposes of exploration, it being doubtful whether the cause of the pyloric tumour was fibrous or malignant, the age of the patient rather pointing against the latter. For this reason the incision was made in the middle line. The appearance of the growth on opening the abdomen was distinctly malignant, and it involved not only the pylorus, but a considerable area of the anterior wall of the stomach, being fixed posteriorly, and several nodules which were presumably enlarged glands, were felt in the lesser omentum. The extent, size, and fixity of the tumour rendered pylorotomy impossible, and the only alternative was to unite a portion of small intestine to the stomach in order to afford a means of outlet for the contents of the latter. The anterior wall of the stomach was chosen for anastomosis, as being more convenient

than the posterior. The commencement of the jejunum at its junction with the duodenum was easily found and a spot about ten inches from this was selected for union with the stomach. Halsted's method of suture was chosen as being easy of application and on account of its bringing a larger area of the surfaces of stomach and jejunum into apposition. After the posterior row of sutures had been introduced two interrupted sutures at each end were inserted as a means of additional security. After the viscera had been opened the cut surfaces of the mucous membrane were united by a few points of interrupted suture, partly to control the hæmorrhage and partly to bring the openings of the stomach and jejunum into accurate apposition. Mr. Murray thought the method by direct suture was preferable to anastomosis either by Murphy's button or by Senn's plates.

It is satisfactory to state that four weeks after operation the patient is going on well; she has had no vomiting, and was able to take solid food a fortnight after the operation. The convalescence has been delayed, however, by thrombosis of the common femoral vein.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JANUARY 17, 1900.

ON THE SANATORIUM TREATMENT OF PULMONARY TUBERCULOSIS.

It is rather a curious thing that the open air treatment of consumption should be sprung upon us now as a new and trustworthy means of combating the disease in spite of the fact that most authorities, from the time of Sydenham downwards, have alluded to it in no uncertain tones as the best, and indeed as the only valid, way of controlling its ravages. But the fact remains that this method until quite recently had never been recognised and adopted as a definite method of treatment. Up to the present indeed it cannot truthfully be said that there has been any definite method of treat-

ment for a disease which levies a heavy toll, year by year, on the population of all European countries. We have had enough and to spare of the so-called specific treatments, not one of which has resisted the experience of a few months or years, but we are now brought face to face with a plan which, in early cases and under favourable circumstances, is unquestionably capable of affording a variable measure of relief. It remains for us to establish what are these circumstances, and the discussion which recently occupied three entire meetings of the Royal Medical and Chirurgical Society, if it has not materially added to our knowledge, has at any rate cleared the air. We thoroughly endorse the preliminary protest uttered by Sir Richard Douglas Powell against the use of such a catch phrase as "Sanatorium treatment" as though the existence of the sanatorium was the indispensable basis of the treatment. We much prefer the term open-air or hygienic method, which term has the merit of placing in relief the conditions which militate in favour of recovery. It simply amounts to this, that a predisposition to pulmonary, and probably to other forms of tuberculosis, is created by living in houses from which fresh air and light are largely excluded. Observation and common sense both point to this as the primary cause of the disease, the greater or less abundance of the infective agent coming after. Under normal conditions of health we can defy the tubercle and most other bacilli, but if vitality is sapped by particular modes of existence the pathogenic organism obtains a footing from which no medicinal treatment yet devised can dislodge it. A good deal of the discussion turned on the architectural requirements of the model sanatorium, but, for the time being, this is perhaps of less importance than the principles which underlie the treatment. It is encouraging to find that there is no material difference of opinion as to the essential value of the method although the details of its application give rise to much divergence of views. One point of considerable importance was made clear, viz., that open-air treatment is one thing, and sanatorium treatment another. No one ever complains of a draught on a mountain top, whereas in the average sanatorium draughts are the order of the day. Fresh air at almost any temperature produces excellent results, but draughts, though they do not necessarily give rise to the familiar cold, are productive of a vast amount of discomfort, and must often cause mischief. The principle may be laid down that, to be effective, the open-air treatment must be maintained throughout the whole twenty-four hours. The vitalising effect of many hours passed daily in the open is minimised by a night passed in a closed bedroom, so that if the treatment is to be effectual it must be continuous. Another fact elicited by the discussion was the importance of collateral measures, such as suitable diet and regulated exercise, as adjuncts to the open-air treatment. Although an abundant dietary is an important auxiliary of fresh air, we must not be led astray

by mere increase of weight, which is by no means synonymous with improvement. It is necessary to bear this in mind, because otherwise we might be tempted to regulate the dietary with the view of obtaining a gain in weight without regard to the physiological requirements of the individual patient. In this connection a point was mentioned incidentally which may prove to have important bearings in the future, viz., the influence of a largely nitrogenous dietary in controlling the disease. Tuberculosis, it is obvious, is rarer among classes of society where meat enters largely into the daily food and carnivorous animals are, as a class, much less prone to the disease than their herbivorous fellows. The data at present available on this point, however, are insufficient to enable us to draw any practical conclusion from the suggestion, and in any event no one scheme of dietary is likely to prove beneficial to all patients without regard to previous habits and personal idiosyncrasy. In discussing the "cure" of such a disease as tuberculosis, it is obviously necessary to define what is meant by the term. Dr. Allbutt went so far as to assert that he would not reckon as cured any patient who had not resumed his ante-tuberculous conditions of existence for a whole year without showing any recurrence of the disease. Measured by such a test the proportion of cures would be small indeed, but Dr. Kingston Fowler knocked the bottom out of this argument by remarking that return to previously-existing conditions of existence is precisely what the cured patient must never aim at. On the contrary, his one aim in existence must be to approximate his future life to the conditions under which he has recovered health. As it is, after all, the conditions of environment that determine the vulnerability of the individual, the individual once again exposed to their debilitating influence will become, if indeed he has not remained, vulnerable. The most interesting point, both for the profession and for the public, is the share in the success of the treatment to be accorded to the sanatorium factor. For the poorer class of sufferers, of course, the sanatorium affords the only means of carrying out the method. It means removal to healthier surroundings, better nourishment, absence of worry, and a higher standard of comfort all round. These, combined with rest, will suffice to turn the scale in, possibly, the majority of cases. But is this sequestration indispensable in the case of persons whose usual surroundings are not unsanitary or comfortless and whose nourishment is not inadequate, in whom, indeed, life in the open air and properly regulated exercise are the principal factors to consider? Surely these patients might carry out the treatment in their homes. They have only to observe the precepts on which all authorities are agreed, open windows, regular habits, and the avoidance of excesses, it being understood of course that the sufferer will conscientiously carry out the injunctions laid down for his guidance. It is here that the personality of the medical direc-

tor of the sanatorium comes into play. He it is who can reinforce the dormant will-power of the patient, and who will induce him to conform to the details of the treatment. The subject as it has been presented in this prolonged discussion is far too wide for us to attempt to deal with in the limits of a single article, and we reserve sundry other points for future reference.

THE SALVATION ARMY SHELTERS.

AFTER several years of litigation the question of the efficient sanitary supervision of the Salvation Army Shelters has been placed on a satisfactory, common-sense, legal basis. The history of the whole matter forms an instructive chapter in the annals of public health administration and development in the United Kingdom. Some years ago the Council prosecuted the owners of a shelter for not being registered as common lodging-house keepers, and in the upshot a decision was given in favour of the Salvationists in the case *Booth v. Ferrett*. The case, however, was reopened by the energetic medical officer of St. George's, Southwark, who traced some cases of small-pox to a large shelter in his district. Finding, therefore, that it was impossible to secure efficient disinfection and sanitary supervision of a large and shifting population of the poorest class he was after a good deal of fruitless negotiation compelled to take stronger measures. Entry was obtained one night under a magistrate's warrant and the gross overcrowding then found became the subject of a magisterial conviction. Practically from this litigation it followed that the Medical Officer of Health and the police had no power of visiting one of these shelters at night, the only time when a domiciliary visit would be of any avail. Moreover, it allowed a professedly philanthropic undertaking to qualify its charity to the extent of charging various sums ranging from a penny to sixpence or more for accommodation, to say nothing of other charges for food, washing, and so on. In this way Mr. Booth's organisation was able to compete against the common lodging-house keepers under conditions that gave him an overwhelming advantage. The whole matter resolved itself into a simple commercial transaction in which stringent and costly regulations were enforced on the one side for the safety of the public, simply to be evaded and laughed at by the other to the great danger of the outside community. Happily, however, the resources of civilisation were by no means exhausted and undeterred by former failures, the London County Council again set to work and instituted a fresh batch of prosecutions, only to be ruled against by the magistrate, who while he expressed general agreement with the contention of the Council nevertheless felt himself bound by the decision of the case of *Booth v. Ferrett* to say that the shelters did not fall within the definition of common lodging houses. The next step was the hearing by the Queen's Bench Division of a special case stated by the chief Metropolitan magistrate.

The Council charged "General" Booth with keeping a certain common lodging-house without being a registered lodging-house keeper under the special Acts of 1851 and 1853. After a long and patient hearing the Lord Chief Justice of England delivered judgment in which he allowed the appeal, so that henceforth the semi-charitable, semi-commercial night shelters will come under efficient sanitary supervision. The learned judge disapproved of the principles that had influenced the decision in *Booth v. Ferrett*. He laid down the important principle that even where a house or building is carried on for charitable objects that fact should not place it outside sanitary supervision. The question was not with what object or motive the house was conducted, but whether the house was so carried on as a lodging-house as to be within the provisions of the Act, as it was clearly within the mischief aimed at by the Act. If large numbers of the most wretched class were lodged in common rooms in sanitary conditions were, in the absence of inspection, supervision, and control, likely to arise, and it was the object of the law to secure efficient control. The common-sense of that view is evident, namely, that so far as the public health is concerned, it does not matter one jot whether the motive actuating the keeper of the shelter be philanthropic or mercenary. The second ground of decision in *Booth v. Ferrett* from which Lord Russell dissented was more technical. The judge in that oft-quoted trial decided that a refuge did not fall within the statute, because a common lodging-house was open to all comers in the sense that the keeper could not refuse admission to any applicant. As a matter of fact the common lodging-house keeper exercised a power of rejection, and there was no legal compulsion that bound him to admit, say, drunken and disorderly persons or those of known evil reputation. The question as to the exact position of charitable night shelters in relation to the local sanitary authorities is now fixed upon a satisfactory basis. To have permitted the state of affairs disclosed by the Vestry of St. George's to have continued would have been seriously to checkmate the progress of public health administration in the United Kingdom. With a full recognition of the good work done by the Salvation Army, we must confess that the position of passive and active resistance assumed by "General" Booth in this matter surpasses our comprehension. He has used the resources of the "Army" to resist the right of supervision by the sanitary authorities of large number of vagrants and outcasts whom he has congregated nightly under conditions proved to have been contrary to the first principles of wholesomeness. He has asserted that the shelters are not conducted on a commercial basis, but has failed to substantiate that assertion by a production of accounts. Indeed, he appears to belong to a class of worthy people who cannot bring their emotional impulses into line with the demands of the community that no individual should interfere with their physical welfare. Were it not for the commercial aspect of the shelters we would say that their emotional aspect would

command the widest respect, even where judgment could not follow. On the whole we concur with the final words of Lord Russell, who said:—"We trust that those who are charged with the enforcement of the law will do all they can consistently with their duty and consistently with effecting the objects of the law to avoid anything like harshness or unreasonableness in its enforcement."

THE DUBLIN HOLOCAUST.

WE are pleased to note that the views which we expressed last week respecting the excessive mortality in the City of Dublin, and its causes, have been considered worthy of notice by everyone of our daily contemporaries in Dublin, and, especially that they have generally confirmed our views by their mature experience. The *Freeman's Journal* alone has acrimoniously differed from us, but its criticism is limited to two points. First that our mortality statistics were not exactly correct. Second that, if they were, the fault for omission to reform the life conditions of the poor does not lie with the Corporation, but with the law which forbids it to acquire building sites compulsorily. On both of these points the *Freeman's Journal* is easy of refutation. The mortality statistics of Dublin are issued weekly, and the figures for this week will not be exactly the same as those of the last. Our figures were substantially accurate according to the most recent returns when the article was written, a few days before publication, but not mathematically correct at the latter date. But what boots such squabbling about decimals? while it is notorious that, for the recollection of the oldest inhabitant of the city, its death-rate taken, not on a week's returns, but on a year's or twenty years' has been, chronically, largely in excess of that of any similarly situated town in the Kingdom, and but little less than that of the most malarious towns of the east. Will the *Freeman's Journal* deny this or will it rack its brains for a passable apology for the fact? Since we wrote the Dublin death-rate, as officially stated, has risen from the 46.0 per 1,000 of the population to 51.3, and the latest returns of the Registrar-General for a whole month set it down as 41.7, the slums of Glasgow being represented by 28.6, and the average of twenty town districts in Ireland as about 25 per 1,000. The second excuse offered by our contemporary for toleration of the present horrible conditions of the habitations of the poor, that the Corporation cannot get sites for new houses except by clearing areas at enormous expense, is equally devoid of substantial foundation. We know that the Corporation has made the citizens pay for the purchase of the occupation rights of a large number of favoured individuals in order to make room for outrageously costly dwellings for artisans who are perfectly well able to pay, for accommodation elsewhere but we repeat that for the housing of the very poor, which we have in view, no such extravagance is necessary. There are several sites for moderate sized dwellings which are derelict and can be had for almost nothing, and which would as they now are be a disgrace to any

Corporation, but a shilling will not be expended on them for the benefit of the very poor. We repeat and insist that there can be no hope of a mitigation of the terrible insalubrity of the City but by improving the life-conditions of the poor, and we see no very great eventual difficulty in doing so, if only the Corporation would take as much interest in the problem as it does in hauling into the City boundary communities which vehemently resist their extinction by annexation.

The urgency of this question may be judged from the fact that the Lord Lieutenant has evinced his earnest interest in the welfare of the poor of the City in which he resides by convening a conference of the Local Government Board, the City Health Officer and His Excellency himself to discuss the situation and the remedy, and we are certain that a wise conclusion will be thus arrived at, but we must say at once, that unless that conclusion embodies the ultimate extinction of the tenement house system, and the substitution of a proper model lodging-house system, it will prove as totally unavailing as several panaceas have done before. For the realisation of such a great aspiration, the co-operation of the Corporation is indispensable. It must find the money, and must indicate its outlay in such a way as not to inflict another intolerable blister upon the overburdened ratepayers, and we earnestly trust that the citizens will not permit any renewal of the ineffectual tinkering of the present system which has been going on for the past twenty years. At least £50,000 must be found as a first instalment, and it must be spent not upon law costs or upon the buying up of the property of any one's bosom friend nor in architects' and builders' jobs, but in providing good, substantial dwellings for very poor people. After that is accomplished it will be necessary to move the poor population into these dwellings without violating their convenience or feelings unnecessarily, and, afterwards, nothing will remain but to extend the system, control it properly, and await a result which must be a long way off.

Notes on Current Topics.

The Contracted Pupil of Deep Slumber.

IT is a point of some clinical importance to bear in mind that during deep sleep the pupils are contracted strongly and that they dilate at once on waking under healthy conditions. An American writer, Dr. Robby, of Boston, has called attention to this fact as giving rise to a possible fallacy in diagnosis. Two children were brought to him with a history of a fall. They were unconscious and in both the pupils were of pinhole size. The knee reflexes of both were active, and in applying that test to one of them the child awoke and the pupils instantly dilated. The second child was not roused by the tapping of the knee, but later upon being awakened the pupils at once expanded to the normal size. Since then Dr. Robby has examined twenty-two healthy sleeping children, and in all of them he found the pupils were of pin-hole size and dilated instantly

upon waking. The practical value of the observation lies in the fact that children often sleep soundly while undergoing an examination that would at once rouse an adult. Indeed, a tired baby presents a picture that resembles in many ways that of narcotic poisoning or cerebral injury. Should the pupils not dilate instantly and equally upon waking the observer will be furnished with suggestive evidence of traumatic or drug injury. The physiological side of the matter has long been set forth in the text-books, but it is doubtful whether its clinical bearing is recognised among medical men to the extent it deserves. The point might readily become a crucial one in medico-legal cases, especially when brought forward to controvert evidence of head injury diagnosed after a brief examination. If Dr. Robby had not discovered the real state of affairs in the two cases above mentioned, he might quite confidently have stated later that they showed signs of cerebral injury.

A New Hospital Scheme.

THE suggestion by Dr. Telfer, of Montreal, that there should be in every house a room which can readily be converted into a hospital ward is without doubt excellent in the abstract. But certain difficulties appear to be insurmountable with regard to its practical realisation. In the first place want of space would, in the majority of households, prevent any such scheme being carried out. The author's idea, however, is not to take up an important part of a house and reserve it for use only in time of sickness, but that one room should be so adapted for hospital use that in half-an-hour, when required, it could be changed into a more or less complete hospital. He suggests, therefore, that the ceiling, walls, and floor should be finished in such a manner as to be readily washed; the furniture so constructed as to be capable of being sterilised, and special arrangements made for a separate lavatory and water closet for the sick persons. That is to say, in order to give full effect to the idea it would be necessary to have special plans made for such a room before beginning to build a house, and then all difficulties would be removed. We do not doubt for a moment that a hospital room as suggested would prove of great use under favourable circumstances. For example as an isolation ward for children suffering from one of the symtotic diseases, or for an operation case, or for obstetrical purposes. In each of these instances the advantages of the arrangement could not fail to become self-evident.

"The Medical Parliamentary League."

ANOTHER effort is about to be made to induce members of the Profession to become organised reformers, and thus an association has been launched with the above title, whose objects will be to do some more tinkering with the proposed legislation for midwives and other things. In truth a curious phase is now prevalent in regard to medical politics. At no time so much as the present has the subject of medical reform degenerated so unmistakably into a

trade. Family quarrels have taken place among a certain class of would-be reformers, and a split in the camp has ensued. Thus the unedifying spectacle is before us of two reforming bodies, each with its own little weekly trumpet bidding for popular favour among the medical public. As a matter of fact, however, this craze of reform is being much overdone. The profession, or at least a large proportion of it, is becoming nauseated with the persistent chatter and garrulous outpourings of those who have constituted themselves the champions of reform. Take for example the vexed question of legislation for midwives. We find that, of course, in the interests of the profession, it has been dealt with (1) by the British Medical Association, (2) by the Corporate Medical Reform Association, (3) by the Incorporated Medical Practitioners' Association, and (4) it is the first matter to which the "Medical Parliamentary League" will devote its energy. That is to say, four bodies, ostensibly working with reform objects in view, have expended, or are now expending, their efforts to make legislation for midwives acceptable to the profession. The only conclusion which can be drawn from this undesirable state of affairs is that a good many practitioners would be much better employed if they were to devote more time to their legitimate calling than wasting it in attempting to pose as medico-politicians.

Infirmiry Nurses and Dancing.

THE nurses of the Fulham Infirmiry, so it has been currently reported, have recently been on the verge of a strike, because their matron endeavoured, to prevent the annual ball. The guardians, however came to their rescue, and decided that there should be no departure from the annual festivity that custom had sanctioned so far as to warrant fixed expectation by the nursing staff. It is said that many of the guardians attended the ball in person, and that is partly the reason why they have adopted their present attitude. We fail to see the necessity for any explanation other than the tendency of latter days to enlarge the boundaries of rational enjoyment so as to include larger and larger sections of the community. Infirmiry nurses belong to a hardworked sisterhood, especially when their lot is cast within the four walls of a Poor-law Infirmiry, where the prevailing atmosphere is anything but rose-coloured and exhilarating. Why they should be deprived of the solace of a yearly dance is past the average comprehension. In the bad old days of Bumbledom the bare proposal of such a carnival would have sent a thrill of horror through the length and breadth of the Poor-law service. Even nowadays the old spirit crops up now and then, so far as nurses are concerned, generally in the person of some sour middle-aged spinster to whom the duties of nurses' superintendent have been entrusted. It is a pleasure, on the other hand, to come in contact with a large staff of nurses under a matron of well-educated and broad-minded modern type, who does not object to dancing and who does not think that the mingling of the

sexes in social intercourse is necessarily demoralising. It is not an uncommon experience that the stricter the moral lacing of an institution the more lax is the nursing administration proper.

The Surgeoncy to the Queen's County Infirmary.

THE long disputed question of the surgeoncy of the Queen's County Infirmary was decided, so far as the new governors have power to settle it, on the 10th inst., by the election to the office, supposed to be vacant, of Dr. Arthur Joseph MacAuley Blayney, formerly resident surgeon and resident physician at the Mater Misericordiae Hospital, Dublin, and lecturer in Biology in the Catholic University. Dr. Blayney qualified in 1893 as M.D. and M.C. of the Royal University, and as a student had a distinguished career. A brief narrative of the events of this election will be interesting. Up to the spring of 1898 the surgeoncy was occupied by Dr. William Jacob, who had the co-operation of his father, Dr. David Jacob, and their joint administration of the institution for a long series of years was not and could not be seriously challenged by their bitterest enemies. When, however, the dominant control of the infirmary passed into the hands of the new County Councils elected under the Irish Local Government Act, the dominant party in that Council thought they saw their way to oust these gentlemen and to substitute one of their own colour, to wit, Dr. Higgins, coroner for the district and dispensary doctor at Stradbally, about eight miles from the infirmary, who possessed the pre-eminent qualification for a hospital surgeoncy that he is brother-in-law to Mr. Tim Healy, M.P. To effect this change a very undiplomatic resolution was passed by the dominant majority, but only by one vote, purporting to dismiss Dr. William Jacob on the ground that he holds the dispensary and the Asylum in Maryboro and, therefore could not effectively discharge the Infirmary duty, an objection which applied obviously, with tenfold force to Dr. Higgins, a candidate who held office ten miles away, and might be called to conduct inquests in all parts at which he might be required to attend as judge for days together. For this and for other reasons to which we need not refer, a large section of the electors split off from supporting Dr. Higgins, and decided to run a second candidate on the same party lines. The original Governors of the Infirmary who support Dr. Jacob refused to take part in any election as they contend that his dismissal was totally illegal, and that he is still, *de facto*, Surgeon to the hospital, and this question of law is about to be submitted to the courts. Thus, when the vote was taken on the Wednesday last, Dr. Blayney was chosen by a majority of one vote, the original Governors abstaining, and Dr. Higgins was completely hoist with his own petard, and the new surgeon will occupy the position unless or until he is unseated on the point of law. The election is of general interest because it is the first occasion on which an Irish county infirmary surgeon has been attempted to be dismissed by the newly dominant party. All such officers who held

office before March 31st, 1898, are safe of their seats, but all appointed since then and all to be elected in future will live at the mercy of the dominant party, who may, and will, wipe them out of existence the moment they blench before the popular political programme.

Tabloids v. Prescriptions.

THE *Pharmaceutical Journal*, in its last issue, charges us with having "impudently asserted that compressed tablets afford facilities for the administration, in minute doses, of the very active alkaloids which the practitioner prudently hesitates to order in a prescription." We did say so, and we adhere to the statement, and call the general practitioner as our witness. We never had the remotest intention to belittle the skill of the pharmacist, but we should like to see the general practitioner who would venture to hand to a patient from the country a prescription for half a dozen pills containing each of them, say a thirtieth of a grain of strychnia, or phosphorus, or strophanthin, or cocaine, or atropine. Our contention is, simply, that such drugs as these cannot be compounded even by the most capable and conscientious chemist without the risk that the entire dose will be concentrated in one or two pills, and we are convinced that the Editor of the *Pharmaceutical Journal* knows this perfectly well. The tabloid makers can grind a drachm or an ounce of strychnia into a multitude of tabloids, but the individual dispenser cannot be certain of effecting the same subdivision with safety for half-a-dozen pills, no matter how hard he tries. Our observations were chiefly directed to persuade the pharmacists that it will be ineffectual and foolish to set up a trades-union opposition to the public buying of tabloids and other conveniently concentrated medicaments. It would be, in our opinion, wiser advice to them if the *Pharmaceutical Journal* would recommend them to adapt themselves to the inevitable change in the public taste, and while not too soon abandoning the dying prescription system, to cultivate the trade in such medicaments.

"Strumous Ophthalmia."

It is not a little remarkable that some ophthalmic surgeons should still persist, in teaching that such a disease exists as "strumous" ophthalmia. A few years ago a "strumous" ulcer of the skin always meant what is now called a "tuberculous" ulcer, and therefore now-a-days to speak of "strumous" ophthalmia can only mean "tuberculous" ophthalmia. But the advance of knowledge has taught that the tubercle bacillus is not answerable for any of the conditions which formerly were described as "strumous" ophthalmia; consequently the retention of this term under the circumstances is quite opposed to the scientific teaching of the day, and is moreover misleading. Again, the word "strumous" having now become obsolete from the introduction of the term "tuberculous," it is safe to assume that within a decade or two more, it will pass altogether out of medical nomenclature. Certainly, neither the modern physician nor the

modern surgeon can have any occasion for reverting to the word "strumous" in the course of his teaching, and hence the modern ophthalmic student is probably at a loss to understand why an ophthalmic surgeon should refer to an ophthalmia as strumous when it has nothing to do with the tubercle bacillus.

Notification of Measles.

SOME of our readers may recollect that when, many years ago, it was proposed to enact the compulsory notification of disease, we strongly advocated the system of voluntary notification, because it was free from the danger that disease would be deliberately concealed by both the patient's friends and by the practitioner in charge, with the object of escaping the domestic annoyance and dislocation of business which necessarily follows upon compulsory sanitation. We urged the adoption of the voluntary system, at least as an experiment, because it had been tested in Greenock for some years previously, and had given complete satisfaction, but the compulsory system now in operation was preferred, and, as we anticipated, has resulted in the concealment of a certain proportion of the infective disease in the country. We recur now to the subject, having observed that the Corporation of Wigan has, at the instance of its medical officer, approved of a further extension of the voluntary system, in the case of measles, for three further years, while in many towns the compulsory system works with much friction, and in very many other towns where it is nominally in force it is a dead letter, no serious attempt being made to bring it into operation.

The Study of Botany.

HEALTHY intellectual life is hardly compatible with too exclusive concentration of the mind upon any one pursuit, especially if that pursuit be at the same time the professional avocation of the individual. Every intellectually active man requires a hobby of some kind, which serves the double purpose of enlarging the scope of his ideas and of providing him with a never-failing source of distraction and amusement. For persons whose life runs its more or less even tenour in the country what more interesting pursuit can there be than botany? Foremost among the natural sciences it helps to develop the mind, and opens it to the beauties that surround one on every hand. It is greatly to be regretted that this charming science does not attract more favourable attention than is the case, and the fault is doubtless to some extent to be found in the neglect shown in the elementary schools towards a subject which, even if cursorily taught, is replete with interest and instruction. From a medical point of view, much as the medical practitioner would profit by a fairly complete knowledge of this branch of observation, the curriculum is already too heavily laden for it to be possible to include it among the studies imposed upon the medical student. But the subject might well be accorded a prominent place among the subjects of preliminary education; indeed, in view of its bearing

on *materia medica* it might even be made compulsory. We commend this suggestion, which emanates from a correspondent who signs himself "An Admirer of White of Selborne," to the Education Committee of the Medical Council, as the preliminary examinations are just now under consideration.

A Case of "Larva Migrans."

UNDER this somewhat indefinite heading a case was recently reported at a meeting of the Toronto Medical Society, and accompanied by a photograph of the patient, showing a sinuous, tortuous line coursing over the pectoral region on the right side. The history was that the line first appeared on the back, and was about one-eighth of an inch in diameter. It increased in length from one half of an inch to three inches and a half every day, then in order to put a stop to these migratory proceedings a "fly" blister—obviously a most appropriate remedy under the circumstances—was applied about one inch beyond the advancing trench works, and the parasite, having failed to recognise the necessity of performing a flank movement, delivered a frontal attack upon the fly-blistered area, as a result of which it fell a victim to a blunder in tactics, and the patient was cured. We are informed that the larva of some insect burrows in the skin in these cases, thus producing the lesion. Precisely, but it would have been more to the point if some steps had been taken in this case to ascertain the nature of the larva and thus have thrown some light upon the subject. As it stands, the case is quite incomplete, and whether the lesion was or was not caused by the bot fly, no one can tell. All that the author is able to assert is that it was cured by the "fly" blister, an assertion, however, which has no value respecting the nature of the "fly" which rendered its application necessary.

The Significance of Chilblains.

THE rounded purple, dusky little swellings that come upon hands and toes in winter are familiar to most inhabitants of cold climates under the name of chilblains. Less often they attack the ears, nose, or cheeks, but wherever situated they give rise to a most troublesome burning and itching sensation. The general rule is that they appear in parts of the body remote from the heart, and are most frequent in the young and old. They are prone to occur in persons who suffer habitually from cold hands and feet, that is to say, in those who have a weak or, what Hutchinson calls, a "chilblain circulation." Anæmia is another predisposing condition. The essential nature of this interesting complaint is that it is a damage to the skin, resulting from cold, in short, a mild frostbite. In some cases it approaches the latter state more nearly by the formation of blisters, when the chilblain is popularly described as being "broken." There is no complaint in which more infallible remedies are prescribed by "hobnail" tradition. A favourite plan is to whip the affected parts with a bunch of stinging nettles, a homely but most efficient form of counter-irritation. A Swedish method is

for the sufferer to run several times barefooted round a field covered with snow. Perhaps one of the best ways of prevention in persons of sluggish temperament is to take active exercise and to wear warm woollen gloves and socks. The latter hint may be of use to those who are sending out comforts to our soldiers at the Cape, where the severe weather is sure to call forth a plentiful crop of chilblains, and add, not a little, to the discomfort of the brave men who are fighting our battles in the open.

The Canary Islands for Convalescent Soldiers.

A CORRESPONDENT, writing to the *Times*, makes the very practical suggestion that advantage should be taken of the situation and climate of the Canary Islands for our wounded soldiers. Certainly at this time of the year the return to England of the wounded and sick must be attended by much discomfort and even danger, while the admirable climate of these lovely islands provides an ideal *milieu* for their recovery.

A Museum of Cataracts.

COLONEL GEOFFREY C. HALL (I.M.S.) seems to have established a record. He states in a small publication that he has operated for cataract in 8,000 cases, and that he has all the extracted "lenses carefully packed in bottles to confute the doubter." Thus he must have quite a museum of cataracts. But we feel in some doubt as to what he means by the "doubter." To whom does it refer? It is not to be supposed that there could be anyone bold enough to doubt Colonel Hall's word that he has done 8,000 extractions. Such a feat, it is well understood, could be quite possible in India, where thousands of natives suffer from cataract. Indeed, this disease prevails to such a large extent, that the operation for cataract is one of the most common in the Indian Peninsula, and many surgeons have done their thousands of cases with, and perhaps, without, benefit to the natives. It is, however, quite a novelty, we believe to keep, as Colonel Hall has done the extracted lenses "to confute the doubter."

A Phenomenal Death Rate.

A DEATH-RATE in the large towns of England varying between 37 and 40 per 1,000 is calculated to divert attention to some extent from the losses which we are sustaining by less normal means in South Africa. Although the leaps and bounds which have characterised the returns for the last few weeks are certainly rather startling, it will be seen that the effect of the epidemic of influenza which is, probably correctly credited with the enhanced death-rate, is mainly exerted on the elderly, indeed an immense majority of the deaths have occurred among persons over sixty years of age. It follows that influenza merely strikes down within a limited space of time a number of persons who would have died in a few weeks or months by efflux of vitality; in other words, when the statistics for the whole year are made up, the average mortal-

ity will not be found to have been appreciably affected by the present high mortality. This reflection is calculated to encourage the timorous, because it goes to show that it is not the result of the disease of itself, which, indeed, is but the precipitating cause of a disaster which was in most cases imminent.

Medical Men and the Auxiliary Service.

A FEW days since we published an appeal signed by several influential members of the profession, urging medical practitioners to show their sense of patriotism by offering their services to one or other of the auxiliary services. The present is certainly an opportune moment for urging this matter on members of the profession. Connection with a volunteer or yeomanry corps offers many advantages, both social and professional. Not only is the medical officer discharging a patriotic duty, but he brings himself, thereby, into contact with a large and influential section of society, and the community of arms constitutes a bond which is not to be despised even from the selfish point of view of professional advancement. The drills afford relaxation, both physical and mental, and the annual manoeuvres provide an agreeable change from the ordinary routine of practice. The expense connected with these posts is not necessarily very heavy though we are fain to admit that the cost of the initial outlay for uniform and equipment appears somewhat inflated, a point which our military authorities might well consider, because it cannot be doubted that the obligation of expending between £60 and £70 on uniform, &c., frightens away many a man who would otherwise be delighted to enrol himself.

The Surgeoncy of the City of Dublin Hospital.

We understand that on Monday, the 8th inst., the Medical Board of the Hospital selected the three applicants for the surgeoncy, who it, is incumbent on them to recommend to the general Board of Governors, who will select one from the three. The names chosen by the Medical Board were those of Mr. Henry Croly, M.B. and M.Ch., and B.A.O. of the University of Dublin, formerly resident surgeon in the Hospital and in St. Mark's Eye and Ear Hospital; Mr. Henry Moore, Licentiate of the Colleges of Physicians and Surgeons, surgeon to the Mercer's Hospital, and formerly resident surgeon in the City of Dublin Hospital; and Mr. Richard Lane Joynt, M.D. Univ. Dub. and F.R.C.S.I., assistant-physician to the Meath Hospital. We understand that the general Board of Governors will meet on Friday next to make the selection from these three applicants.

The "Reuben Harvey" Memorial Prize.

THE approaching award of this prize, which is given triennially by the Colleges of Physicians of Ireland for the best essay on some subject evidencing original research in animal physiology and pathology will be made on July 2nd, 1900. The prize consists of £25, and the competition is open to all students of medical

schools recognised by the Colleges, and also to all licentiates and graduates of not more than three years' standing. The competing essays must be lodged with either of the Registrars of the Colleges before June 1st.

THE epidemic of influenza is so severe in Birmingham that many thousands are under medical treatment, and twenty-two deaths were attributed to it last week.

PERSONAL.

MR. ALFRED D. FRIPP, assistant surgeon to Guy's Hospital, is on his way to the front.

DR. T. B. COLEMAN, F.R.C.P.I., has been appointed to the staff of Lord Iveagh's Irish Hospital for South Africa.

SURGEON-CAPTAIN P. H. WHISTON, Royal Army Medical Service, has been appointed to the medical staff in the Home District.

DR. EDGAR A. BROWNE was elected president of the Liverpool Medical Institution for the ensuing year at the annual meeting held on Friday last.

DR. BACCELLI, the Minister of Public Health in Italy, has consented to inaugurate the new School of Tropical Medicine in this country in May next.

DR. JOHN SHOOLBRAID has been awarded a pension of £50 per annum by the Aldershot District Council on his retirement as Medical Officer of Health of Aldershot.

DRS. MCCORMACK and SCOTT SKIRVING, two of the leading surgeons of Sydney, are accompanying the New South Wales Contingent to the front where they will have the honorary rank of major.

DR. W. CHEYNE WILSON has been appointed by the Admiralty to give instruction in the use of the Röntgen Rays to naval medical officers who will, as occasion permits, be sent to the Naval Hospital, Plymouth, for that purpose.

THE additional sum of £10,000, which the Earl of Leicester has promised to the Norfolk and Norwich Hospital, brings up the total benefactions of the noble earl to this hospital to £50,000. The new building to which the latest contribution is promised is to be called the Leicester Home for Nurses.

MR. DOWNES, the president of the Pharmaceutical Society of Ireland, has found it necessary to resign his office, and his retirement has been accepted by his colleagues with unanimous expressions of regret and sympathy. Mr. Downes met with a serious street accident many months ago, and, unfortunately, has not regained health as he recovered from it. His occupation of the presidential chair has been marked by energy and discretion such as few presidents evince, and it fell to him to deal with the knotty question of company pharmacy, which he did wisely, though the result of his work has yet to come.

A Few days ago Mr. Richard Gravely, M.R.C.S., was presented with a jubilee testimonial to mark the completion of his 50 years' residence in the village of Newick, Surrey. The testimonial consisted of a solid silver antique inkstand, a pair of silver candlesticks, a case containing a silver pen, pencil, and paperknife, a cheque, and an illuminated address. On the inkstand is engraved: "Presented to Richard Gravely, Esq., resident in Newick 50 years—1849-1899—by his many friends," and the address itself states: "That the presentation is in token of their appreciation of the constant interest shown by him in the welfare of the inhabitants of Newick and the neighbourhood during his 50 years' residence among them."

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

SICK AND WOUNDED OFFICERS' SURGICAL AND MEDICAL AID FUND.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I shall be glad to be afforded the opportunity of making an appeal in your columns on behalf of those sick and wounded officers of all services whose means are inadequate to secure that efficient medical and surgical treatment which will often be needed to restore to them, after their return home, the health they have sacrificed in the service of their country. Among the great number of officers who have unhappily been wounded or are suffering from disease contracted on service there will certainly be many who have small private means, and who are not in a position to command the skilled assistance they will urgently need. In many cases continuous treatment for long periods will be necessary. Though to offer assistance in such cases will be a matter of considerable delicacy, nevertheless I feel sure that it will be generally felt that an attempt should be made to do so.

The under-mentioned gentlemen have consented to act upon a general committee, and to assist the objects of the scheme in every way within their power. A fund has been opened to which I earnestly trust many of your readers will readily contribute. The provision of accommodation for convalescent patients is a part of our scheme, and I have already received several offers from private persons which I have no doubt that the committee will be glad to entertain.

Subscriptions may be sent to Messrs. Coutts, Strand, London; the Duke of Abercorn, Hampden House, Green Street, W.; or to the Honourable Arthur Brodrick, 18, Eaton Square, S.W. (hon. secretary and treasurer to the fund, to whom inquiries may be addressed). Cheques should be crossed "Sick and Wounded Officers' Surgical and Medical Aid Fund."

I am, Sir, yours truly,

ABERCORN.

Hampden House, 61, Green Street, London, W.,
January 11th, 1900.

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Honorary Secretary and Treasurer.

BACON RASH—A QUERY?

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—During the recent epidemic of measles whilst attending a sick bed I noticed that the patient's mother was covered over face, breast and arms with a rash which very closely simulated measles. On inquiry I found she was subject to the rash every time she ate bacon, either boiled or fried, and had been so from childhood. The diet caused her no other inconvenience than keeping her within doors for twenty-four hours. About one hour after eating the food the rash appeared, first showing on the face and then spreading to the chest and arms. It finally faded away in the order in which it came. The woman's temperature was normal, her appetite good, and she attended to her household duties as usual. She enjoys a dinner of bacon and would eat it more frequently if it were not for the rash which certainly follows its use. The quality of the bacon used is the best Irish, so the rash cannot be ascribed to diseased food.

Bacon is so largely used as a food that I thought it probable that some other practitioner might have come

across an identical idiosyncrasy, but a careful search of Dr. Neale's "Digest," last edition, and some other reference books failed to find a reference to an identical case, hence my letter.

I am, Sir, yours truly.

GEORGE FOY.

"A SAD AND URGENT CASE."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I beg to enclose you a list of donations up to date in response to the appeal of Dr. Macnaughton Jones, which I have received subsequent to the previous one, which you kindly published. Will you be so good as to favour this, likewise, with an insertion in your journal?

I am, Sir, yours truly,

WILLIAM H. BOURKE, M.D., Hon. Treas.

	£ s. d.		£ s. d.
Dr A. Duke	0 10 0	Dr H. B. Pope	0 10 6
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Rev. D. J. Forbes	1 1 0	Dr J. Shaw Lyttle	0 5 0
		Mrs. Hemans	2 0 0
		Mis Low	1 1 0

8, Moreton Gardens, South Kensington, S.W.

January 10, 1900.

P.S.—I would wish to say that the list or this very sad case will remain open till the 27th inst.

Obituary.

DR. ROBERT COLLUM.

THE death of Dr. Robert Collum, of Furbiton, at the advanced age of 86, creates a solution of continuity with a very interesting chapter of history. He qualified as for back as 1836, and subsequently entered the service of the Honourable East India Company, where he was for long attached to Sir Charles Napier's staff, indeed he was alone in medical charge of the 55th on the "Zenobia," a transport on which cholera broke out, killing 64 soldiers in eight days. This, however, was but an incident in a long career, which bristled with responsibilities and adventures. On his return in 1857 he took up the cause of the members of the Royal College of Surgeons of England, becoming president of their society.

THE past ten days has produced a deplorable mortality amongst well-known members of the profession in Ireland.

DR. HUMPHRY MINCHIN died in London at a very advanced age, having withdrawn some years since from all professional practice. He took his first qualification at the Irish College of Surgeons in 1838, and his university degree at Trinity College in 1840. He served in early life as Medical Officer of the Castlereagh Dispensary, and afterwards, for a long period, as Medical Officer of the North Dublin Union and Physician to the City Prisons. He was also Professor of Botany in the School of the Irish College of Surgeons until that chair was abolished. Dr. Minchin was deservedly esteemed in a social sense. He acted as treasurer of the Irish Medical

Association for many years, and was familiar with Dublin social circles as an accomplished musician—a very skilled composer as well as a performer.

Dr. SAMUEL ROBERT MASON died last week most unexpectedly at his residence in Merrion Square, Dublin, at the early age of 47. He was the eldest son of Dr. Thomas Peter Mason, well-known as the founder, with Mr. Ledwich, of the Ledwich School. He took his first qualification from the Irish College of Surgeons in 1873, and followed it up with the M.D. of the University of Dublin and the Fellowship of his College. He devoted himself to the practice of obstetrics, at which he was very successful, becoming afterwards Professor of Midwifery in the College and Master of the Coombe Lying-in Hospital. He accepted the latter appointment when the hospital was in most adverse circumstances, and was very successful in restoring it to its former régime. We understand that he was taken ill in his bed at midnight, and died before medical aid could be obtained.

Dr. STEPHEN O'SULLIVAN, of Cork, joined the profession as M.D. of the Queen's University, and L.R.C.S., Edin., in 1862, and speedily rose in rank in his native city. He became house surgeon of the North Infirmary, and afterwards full surgeon of that, and several other similar institutions. He then became Professor of Surgery in the Queen's College, and served as Secretary of the Surgical section of the British Medical Association, when it met in Cork in 1879. Having enjoyed the confidence of the public for many years, he died at the age of 64.

Dr. HUMPHRY JOHN BROOMFIELD died also very unexpectedly last week. He commenced professional life as a Licentiate of the Dublin Colleges in 1881, and associated himself with teaching in the Carmichael College where he was Lecturer on Anatomy. At the same time he was Assistant Physician in the City of Dublin Hospital and when the Carmichael College was merged in the school of the College of Surgeons, he became college anatomist in the latter institution. A few years since he accepted the surgeoncy of the Carlow County Infirmary, and thereafter practised in that vicinity. It is understood that he had recently suffered from some internal disease, but did not undergo operation for it.

Dr. ROBERT LINDSAY HUNTER died at his residence in Larne, near Belfast. He qualified in 1868 as M.D. and M.Ch. of the Queen's University, after which he practised in England for a little. During the Franco-Prussian war he was engaged as a surgeon at the front, and, escaping from Metz during that memorable siege, he fled to America, from which country he returned to his native place. For upwards of twenty-eight years he practised in Larne, and relinquished his duties about a year ago in consequence of failing health. Besides his private practice, he held the important appointments of Admiralty surgeon, medical emigration inspector, and medical attendant to the constabulary, coastguard, the naval reserve, and lighthouse staff in the vicinity of Larne.

Literature.

KEEGAN'S RHINOPLASTIC OPERATIONS. (a)

COL. KEEGAN's name has for some years been honourably associated with the plastic surgery of the nose, and the profession will be glad of this opportunity of studying his methods of procedure in detail, and of observing the results thereby obtainable. This can now be conveniently and well done, for in the book before us the type is unusually clear, the printing does not show through the pages, and the reproductions of the photographs are highly demonstrative and artistic, and the "turn out" highly creditable to the publishers.

Col. Keegan remarks that his rhinoplastic operations were performed at Indore, in Central India, where he was

residency-surgeon for 15 years, where "cutting off the nose is frequently resorted to, not only among organised belligerents, but as a means of avenging personal grievances."

All of his operations were on healthy persons whose noses had been cut off; he had not to operate in the wake of an attack of syphilis or lupus, which, of course, was greatly in his favour.

According to a letter in the "Gentleman's Magazine," of October, 1794, the Indian operation, the design of which has been adopted by Col. Keegan, has been employed "from time immemorial," but Keegan has materially improved the original method, and he is magnanimous enough to say that even his work has been improved upon by his *confère*, Capt. Henry Smith, M.D.

The book is very pleasantly written, and is entirely free of bombast. Every surgeon who henceforth lays himself out to operate upon truncated noses will be sure to turn to Col. Keegan's book, which may truly be regarded as the nasal architect's *vade mecum*.

ARCHIVES OF NEUROLOGY. (a)

THIS large volume, the result of investigations in the pathological laboratory, of the London County asylums, is an earnest of much good work done and much to do. It contains a large number of papers, many of them contributed by Dr. Mott and Dr. Barratt. In his first paper on the relation of syphilis to organic brain disease and insanity, Dr. Mott treats of the difficulties in the way of historical investigation. It is to be hoped that asylum clinical records are not so scanty as the following statement would suggest:—"I have seen the most obvious syphilitic residua overlooked in the notes of cases in the asylums. . . . even such coarse objective symptoms as hemiplegia and facial paralysis have occasionally not been recorded in the notes." The second paper on brain syphilis in hospital and asylum practice, also by Dr. Mott, is a very important one, containing as it does notes of 60 cases and 23 post-mortem examinations. The date of incidence of syphilitic nervous diseases is touched on fully and the views of authorities are quoted. Dr. Ferrier's statement at Edinburgh, 1898, is quoted and evidently endorsed by the author, thus, "his (Ferrier's) experience led him to associate tabes and general paralysis with syphilis to such an extent that he assumed that a man suffering with either of these diseases had been affected." The evidence of syphilis as antecedent in all such cases has not been proved. Mott has demonstrated a larger proportion than was previously known or suspected. There is still a residual unknown quantity, and where syphilis has been demonstrated it has to be demonstrated further that it is the essential factor. Several papers deal with different phases of the study of general paralysis—e.g., the condition of the blood, the amount of water and phosphorus contained in the brain and spinal cord, juvenile general paralysis, &c. A paper of some interest to asylum men is contributed on the "Etiology of Asylum Dysentery," by Mr. H. E. Durham, and a rare specimen of telangiectasis is described by Mr. C. F. Beadles. The volume contains numerous good illustrations, and the papers all through are worthy of the archives.

WILSON'S VICE AND INSANITY. (b)

Dr. WILSON's book is a further evolution of his work on Drunkenness. He here treats of alcoholism from the moral, physiological, pathological, and clinical point of view. We should add also that he has made a careful psychological attempt to explain the reduction of function in alcoholism. His physiological explanation of the effect of alcohol on the neuron, and the consequent effect on mental control is very ingenious to say the least of it. His argument is that nerve force—whatever it may be—circulates in the nervous mechanism constantly, just as much as does the circulation, and unless there is this con-

(a) "Rhinoplastic Operations." By D. F. Keegan, M.D., F.R.C.S., Indian Medical Service, retired. London: Baillière, Tindall, and Cox. Pp. 72. 1900.

(a) "Archives of Neurology." Edited by F. W. Mott, M.D., F.R.C.S. London: P. S. King and Son. 1899.

(b) "Vice and Insanity." By George R. Wilson, M.D. Edinburgh: William F. Clay. 1899.

stant, mild state of stimulation metabolism becomes a dynamical impossibility. This function of nerve motion he calls "tonic," and the effect of alcohol, he holds, is to produce a tonic depression. There is perhaps not anything very new in this, for we have heard of functional activity calling for fresh blood supply; but it is interesting as being expressed in terms of modern physiology, and apparently letting in more light. In his general conclusions on the effects of alcohol we cannot help feeling that the author is sometimes too drastic, and that he has never been able so fully to investigate what we may call the physiological field of the temperate drinker as compared with the pathological of the chronic soaker and the dipsomaniac. A number of interesting clinical cases are given.

Literary Notes and Gossip.

THE "Pocket Case Book for Nurses" (Scientific Press), has been compiled with the object of inducing those in charge of the sick to cultivate the habit of accurate and precise observation. It contains forms for a large number of records, each embodying details of identity and bodily functions, systematically arranged and tabulated. The idea is good, and the plan seems likely to attain the object in view.

THE Watford magistrates a few days since, ordered the destruction of a large number of books seized on the premises of the "University Press Co., Ltd.," on the ground of obscenity. Among them we learn is Féré's "Expression of Emotions" and Havelock Ellis's work on Sexual Pathology. Mr. Féré will be disagreeably surprised at the notoriety thus given to his work.

"The burden of an honour
Unto which he was not born."

THE little "Manual for the Church Lads' Brigade Medical Corps" (2nd edition), is an extremely succinct and handy little volume for the guidance of those who are organising a "first aid" course. After laying down the main lines of the organisation and scheduling the equipments, we have sketched out for us the subjects for instruction, theoretical and practical, with precise directions for the diagnosis and summary treatment of injuries. Then comes ambulance drill with rules for service. Though quite a "pocket" edition, the cost being only sixpence, it is a marvel of concision and comprehensiveness, and it constitutes a trustworthy guide to a very useful course of instruction and training.

AMONG our American brethren medical men are coming well forward as authors of non-professional works. Dr. Weir Mitchell's "Autobiography of a Quack" has just concluded in the "Century Magazine"; Dr. Wm. M. Polk's "Life of Leonidas Polk, Bishop and General," has been a great success; and Dr. J. Allen Wyeth's "Life of N. B. Forrest," the brilliant cavalry leader of the Confederates, is one of the most valuable contributions to the Inter-States War we have seen. It is furthermore a most carefully-prepared biography and most impartial record of a great life. The author's hero stands forth from the canvas, no fault overlooked, no virtue exaggerated—a great man, worthy of an excellent biography.

YET another of the "Golden Rules" series (John Wright, Limited, Bristol), the subject this time being Psychiatry, the text being furnished by Dr. J. Shaw, of the Grove Hall Asylum. Briefly treated under the four heads, diagnosis, prognosis, treatment, and certification, we have a valuable series of hints and suggestions for dealing with the insane. These will be found very serviceable by the general practitioner, whose experience in this department is necessarily somewhat limited, especially as advice is added in respect of the legal position of patients requiring to be certified. This little volume will certainly add to the popularity of the series, and should take its place alongside of the "What to Do in Cases of Poisoning" in the practitioners library of reference.

THE 1900 edition of the "Formulaires des Médicaments Nouveaux," by H. Bocquillon-Limousin (Baillière et Fils, Paris) brings the work well up to date by the inclusion of the most recent additions to the domain of therapeutics. The list of additions is too long for mention, and we must confess that few, if any, of them are familiar to us, or indeed, known even by name. A little work of this kind is just what the busy practitioner requires, and we regret that it is in a foreign language, which must limit its usefulness in this country. We cannot shut our eyes to the progress that is being accomplished in pharmacy and what we may call pharmaceutical therapeutics, but it is often difficult to put one's finger on the requisite information at the right moment. This work enables us to do so.

QUITE a model of what a student's journal should be is the last issue of "The Broad Way," published by the Westminster Hospital students. The scientific side of the journal is furnished by an important paper by Sims Woodhead on "Natural Protective Agencies against Specific Infection," being the Sturges Lecture attached to the Westminster School. Of the rest of the text a good deal naturally deals with things of special interest to Westminster men. The frontispiece cleverly depicts Mr. Stonham, surgeon to the hospital, riding in armour on a steed caparisoned and trapped with a host of saws, syringes, forceps, lithotrites and other surgical *armamentaria* in the Lord Mayor's procession. As a production of students alone and unaided the January number of "The Broad Way" is decidedly in advance of anything of the kind that has come under our editorial notice.

THE double section of the "Oxford English Dictionary," published this month, includes words from Glass-coach to Graded. The section is edited by Mr. H. Bradley. It contains 1864 main words, 588 combinations explained under these, and 578 subordinate entries; in all 3030. The obvious combinations, recorded and illustrated by quotations, but not requiring individual explanation, number 645 more. Comparison with Dr. Johnson's, and some more recent dictionaries, shows the following figures:—As evidence of the enormous increase of words over any other dictionary hitherto published may be here recorded that in this section alone from Glass to Graded, 3,675 words are recorded, whereas in Johnson there are 313, in Cassell's 1565, in the Century Dictionary 1875; whilst the number of illustrative quotations, here are 15,816 against Johnson's 1102, Cassell's 1047, Century Dictionary 1907.

ONE of the most fascinating medical autobiographies ever written is that of the late Dr. Arthur Hill Hassall. As an investigator, worker, and writer, his period of active life extended over nearly sixty years. His early tastes were in the direction of natural history, and led to the study of zoophytes, about which little was known at the time. His chief work was on the adulteration of foods, upon which he became the greatest living authority, and his labours led to the appointment of a Parliamentary Committee of Inquiry and later to legislation. After a serious illness in 1886, he went to Ventnor with so-called fibroid phthisis of one lung. There he founded the well-known Hospital for Consumption, and on leaving in 1887 he was presented with a service of plate, and a purse of 330 guineas. Shortly afterwards he left for San Remo, where he passed the rest of his days.

MM. BAILLIÈRE ET FILS, of Paris, publish two monographs presenting a certain interest, one on non-diabetic glycosuria, by Dr. Roque, and the other on the diagnosis of diseases of the cord, by Dr. Grasset. The former deals with more or less permanent forms of glycosuria which requires to be distinguished from diabetes proper. These forms all present the common characteristic of never being "idiopathic," but, on the contrary, secondary and merely symptomatic. Dr. Roque describes four varieties of this kind of glycosuria and discusses the appropriate treatment of each. Dr. Grasset's little work is an excellent guide to the exact diagnosis of disease of the spinal

cord by physiological observation. Given a patient presenting symptoms of a spinal lesion, how are we to locate the seat of the lesion, and determine what system or systems are mainly, or exclusively, involved? These are the questions which Dr. Grasset sets himself to reply to, and he has succeeded to a great extent in doing so within the limits of this short monograph.

Laboratory Notes.

BYNO-GLYCERO-PHOSPHATES.

WE have received from Messrs. Allen and Hanbury, Limited, a sample of Byno-Glycero-Phosphates. This is a combination of the popular glycerophosphates with bynin liquid malt, and the result strikes us as being extremely satisfactory. With the tonic and reconstituent effects of the glycerophosphates, we get the nutritive and digestive action of the bynin, an association of properties well calculated to prove of service in the treatment of persons suffering, or recovering from, debilitating and emaciating diseases, and generally in conditions of mal-nutrition and debility. The mixture is quite palatable, and is not likely to be objected to even by fastidious patients.

CULINARY DELICACIES.

MR. VICTOR BENOIST, the well-known manufacturer of invalid and dietetic foods, of 36, Piccadilly, has submitted to us samples of his "Consommé de Volaille" and "Turtle Soup." The palatableness of such products is of even greater importance than their alimentary value, but while both must take first rank among culinary delicacies, it is hardly necessary to point out that a "Consommé de Volaille" prepared by skilled hands is an ideal article for invalid dietary, though it is sure to be highly appreciated even by those whose health leaves nothing to be desired. The Turtle Soup is not less commendable and is certainly not less satisfying. It is important to know that these products can be obtained without difficulty in hermetically sealed jars, practically ready for use, in any part of the country. Their keeping properties are remarkable, indeed we are not prepared to assign a limit, never having alighted on an unfavourable specimen.

ANTI-KAMNIA AND CODEINE.

"ANTI-KAMNIA" is the pharmaceutical name of a product briefly described as "a new synthetical coal-tar derivative of the series $C_{20}H_{22-6}$ into which the amines have entered," and elsewhere as having for its base "the derivatives of the amido-benzoles." It is introduced as a powerful analgesic for the suppression of the symptom pain of neuralgic and rheumatic origin. It is specially claimed that it does not exert any depressing influence on the cardiac function.

We have received a sample of tablets containing anti-kamnia in association with codeine in the proportion of 4.75 grains of the former, and .75 grain of the latter. This combination is recommended as being well calculated to subdue pain in cases where a pure analgesic fails to afford complete relief, as in muscular spasms, asthma, &c. The tablets are best given one at a time, at intervals of about half an hour, until three or four have been administered. The relief given in certain cases has certainly been well marked though in view of the small quantity of codeine present the effect was probably due in major part to the anti-kamnia constituent. Our experience has not been sufficiently extended to allow of a comparison of its efficacy with that of analogous drugs, or combinations of drugs, but, after all, what the patient requires is relief from suffering, and not a more or less accurate estimate of the comparative effects of the constituents.

What is an Adequate Salary?

If a medical man of special competence and experience is to devote his whole time to the onerous and responsible duties attached to the post of medical officer of health it is obvious that a sufficient salary must be provided to enable him to live in comfort and independence. The Local Government Board are of opinion that for a

town the size of Scarborough, an annual remuneration of not less than £500 should be allocated, but the Corporation have just reiterated their view, already expressed, that £375 should suffice. Surely this is a very shabby attitude for the governing body of a flourishing health resort to take towards an officer, whose services are of special value and importance in such a town! We trust that the larger-minded members of that body will reconsider the matter, and so put an end to a very undignified dispute, the more so as the Corporation is certain to give way ultimately.

Small-Pox in London

THERE has been a sudden accession during the past week to the numbers of small-pox patients under treatment at the Isolation Hospitals of the Metropolitan Asylums Board. Some seventeen persons are now under treatment, and it is worthy of note that two of them were originally certified to be suffering from scarlet fever. One of these proved to be the victim of hæmorrhagic variola, and has since died. Occasional errors of this kind are quite unavoidable in the early stages of the disease, but the usual mistake is to describe it as measles. Arrangements have been made for any future cases to be received at the Gore Farm Lower Hospital.

Fraudulent Brandy.

LAST week a West-End grocer was fined twenty guineas for selling as "Three Star Brandy" of an eminent firm spirit which he had bought at a sale, bottled and placed labels on of a fraudulent description. Messrs. Martell and Co. have found it necessary to warn the profession and the public to be on their guard against the selling of inferior brandies, which in most cases are not grape spirit at all, in bottles bearing an imitation of their well-known blue and silver label, and the filling-up of their own empty bottles with other brandies. In buying a bottle care should be taken to see that the blue capsule is intact.

A Well-Merited Protest.

MR. THOMAS BOND, the well-known police surgeon, recently made a public protest as to the treatment of bodies recovered from the Thames. He informed the Coroner that the body had been left lying on the steam-boat pier, covered only with a coat, the police declining to remove it until the overseer had been communicated with. It seems that there is an antiquated rule, dating from the reign of George III., enjoining this course; but it should have been sufficient, one would imagine, to call attention to this anachronism for the rule to be modified or abolished, in the interest of public decency.

Liverpool Medical Institution.

At the annual meeting held January 11th the following list of office-bearers and committees were adopted; those marked * did not hold the same office last year:—President: *Edgar A. Browne, F.R.C.S. Ed. Vice-presidents: A. Bernard, M.B., T. B. Grimsdale, M.B., *T. R. Bradshaw, M.D., and *W. Thelwall Thomas, F.R.C.S. Hon. treasurer: *H. Briggs, F.R.C.S. Hon. general secretary: J. M. Hunt, M.B. Hon. secretary to ordinary meetings: *John E. Gemmell, M.B. Hon. librarian: W. Termewan, F.R.C.S. Council: W. Alexander, F.R.C.S., R. A. Bickersteth, F.R.C.S., T. M. Dawson, M.R.C.S., A. Burns Gemmell, M.B., J. J. O'Hagan, M.B., *A. M. Paterson, M.D., *W. Macfie Campbell, M.D., *James Armstrong, M.B., *Owen Bowen, M.R.C.S., Andrew Stewart, L.R.C.P., *W. T. Clegg, M.R.C.S., and *J. C. M. Given, M.D. Auditors: *A. Burns Gemmell and Charles G. Lee, M.R.C.S. Pathological and microscopical committee: J. H. Abram, M.D., F. H. Barenelt, M.D., R. A. Bickersteth, F.R.C.S., *R. J. M. Buchanan, M.D., A. W. Campbell, M.D., F. C. Larkin, F.R.C.S., C. Macalister, M.D., G. P. Newbolt, F.R.C.S., Frank T. Paul, F.R.C.S., and C. S. Sherrington, F.R.S. Journal committee: The Hon. Secs. to Ordinary Meetings and Pathology Section, F. H. Barenelt, M.D., S. B. Grimsdale, M.B., F. C. Larkin, F.R.C.S., Charles G. Lee, M.R.C.S., C. J. Macalister, M.D., G. P. Newbolt, F.R.C.S., and W. Termewan, M.D.

Notices to Correspondents, Short Letters, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

LOCAL REPORTS AND NEWS.—Correspondents desirous of drawing attention to these are requested kindly to mark the newspapers when sending them to the Editor.

READING CASES.—Cloth board cases, gilt lettered, containing twenty-six strings for holding the numbers of THE MEDICAL PRESS AND CIRCULAR, may now be had at either office of this journal, price 2s. 6d. These cases will be found very useful to keep each weekly number intact, clean, and flat after it has passed through the post.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

REPRINTS.—Authors of papers requiring reprints in pamphlet form after they have appeared in these columns can have them, at half the usual cost, on application to the printers before the type is broken up.

X. B. (Bradford).—The Colonial Office has at last officially recognised the Liverpool School of Tropical Medicine. Seeing the enterprise and good work which this school has already evinced, such recognition could not have been longer delayed.

EDINBURGH STUDENT.—The formation and gelatine method of mounting pathological specimens yields beautiful results, but the objection to it is that it is too costly.

SPEE.—The procedure is not in accord with the ethical rule of the profession.

THE HALO OF AFFIXES.

The members of the American Medical Association are entitled in future to append to their names the letters M.A.M.A., which looks endearing, but if properly interpreted merely indicates membership. How our American *confreeres* must envy us the large and varied assortment of letters to which we, or some of us, take as a right! A simple M.D. isn't it with the possessor of a large portion of the alphabet tacked on to his family name.

Meetings of the Societies and Lectures.

WEDNESDAY, JANUARY 17TH.

SOCIETY OF ARTS.—8 p.m. Mr. A. Rigg: Ventilation without Draughts.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square).—At 4.30 p.m. Dr. T. D. Savill: "Pustular Diseases" (Post Graduate Course).

THURSDAY, JANUARY 18TH.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Tichborne Street, Edgware Road).—8.30 p.m. Annual General Meeting and Conversazione.

ROYAL INSTITUTION.—At 3 p.m. Dr. Rivers on "The Senses of Primitive Man."

WEST-END HOSPITAL FOR DISEASES OF THE NERVOUS SYSTEM.—At 5 p.m. Clinical Demonstration. Dr. Harry Campbell: "Cases of Locomotor Ataxy, and other Disorders of the Gait."

FRIDAY, JANUARY 19TH.

EPIDEMIOLOGICAL SOCIETY OF LONDON (11 Chandos Street, Cavendish Square, W.).—8.30 p.m. Meeting.

ROYAL ACADEMY OF MEDICINE OF IRELAND.—Surgical Section. The exhibition of cases and demonstrations thereon. The cases will be as follows:—Mr. H. G. Croly: Tracheotomy for Epithelioma of the Epiglottis and Larynx. Mr. Lentaigne: Resection of Goitre by aid of Local Anæsthesia by Cocaine. Mr. MacArdle: Three Cases of Resection of Intestine. Mr. Swan: Foreign Body in the Knee-Joint Demonstrated by the X-rays and removed by Section of Patella. Mr. Heuston: Ligation of Subclavian Artery for Axillary Aneurism. Mr. Chance: Ligation of Popliteal Artery for Aneurism.

Vacancies.

Brecon Infirmary, South Wales.—Resident House Surgeon, unmarried. Salary £90 per annum, with furnished apartments, board (all food except beer), attendance, fire, and gas.

Catholic University Medical School.—Lecturer on Dentistry. Applications to Registrar, Medical School, Cecilia Street, Dublin. (See advt.)

City of Dublin Hospital.—Annual Election for Resident Medical Officers. Applications to Honorary Secretary of Medical Board, Mr. G. Jameson Johnson, F.R.C.S.I. (See advt.)

Dundee Combination Poorhouses and Hospital.—Resident Medical Officer. Salary £100 per annum, with board and furnished apartments. Apply to the Clerk of Council, Dundee.

Glamorgan County Asylum, Bridgend.—Junior Assistant Medical

Officer, unmarried. Salary £150, with board, apartments, washing, and attendance.

Grove Hall Asylum, Bow, London.—Junior Assistant Medical Officer. Salary £120 a year, with board, apartments, washing, and attendance. Personal application to Medical Superintendent desirable.

Nottingham General Hospital.—House Surgeon for two years. Salary commencing at £100, with board, lodging, and washing.

Northampton General Infirmary.—Assistant House Surgeon, unmarried. Salary £100 per annum, with furnished apartments, board, attendance, and washing.

Plymouth Borough Asylum.—Assistant Medical Officer, unmarried. Salary £125 per annum, with furnished apartments in the Asylum, board and washing free.

St. George's Hospital, London.—Curator of the Museum and an Assistant Curator. Salary £100 for the Curator, and £50 a year for the Assistant Curator.

St. Mark's Hospital for Fistula and other Diseases of the Rectum, City Road, London.—Honorary Physician. Also House Surgeon for not less than six months. Salary £50 per annum, with board, lodging and washing.

Torbay Hospital, Torquay.—House Surgeon. Salary £100 per annum and £5 for nurses' lectures. Board, lodging, washing, and attendance provided (wine, spirits, and beer excepted).

West Kent General Hospital, Maidstone.—House Surgeon, unmarried. Salary 100 guineas per annum, with board and residence, &c., rising 10 guineas a year to 120 guineas.

Whitehaven and West Cumberland Infirmary, Whitehaven.—House Surgeon. Salary £120 per year, and £30 a year for dispensing, with furnished apartments and attendance.

Appointments.

Bailes, Norman Christian, M.B., B.S.Durh., Resident Surgeon to the General Dispensary, Birmingham.

Blandford, L. J., M.B., B.S.Durh., House Surgeon to the Royal Infirmary, Newcastle-on-Tyne.

Dyer, S. Reinald, M.D.Bru., M.R.C.S., L.R.C.P.Lond., D.P.H., Medical Officer H.M. Prison, Stafford.

Field, A. T., M.R.C.S., Medical Officer for the Wymondham Sanitary District of the Melton Mowbray Union.

Goffe, E. G. L., M.B.Lond., L.R.C.P., M.R.C.S., Assistant Medical Officer at the Lewisham Union Infirmary.

Gofton, Edward, M.B., B.S.Durh., Assistant House Surgeon to the Royal Infirmary, Newcastle-on-Tyne.

James, M. B., M.B., Ch.B.Vict., Assistant Medical Officer for the Workhouse and Infirmary of the parish of St. Mary, Islington.

McConnell, Jas., M.B., B.S.Durh., House Surgeon to the Royal Infirmary, Newcastle-on-Tyne.

MacGowan, J. S., M.D.Lond., M.R.C.S., Medical Officer for the Fifth Sanitary District of the Township of Oldham, Oldham Union.

Morrison, R., L.R.C.P., L.R.C.S.Edin., Medical Officer for the Duffell Sanitary District of the Belper Union.

Muirhead, Jas., M.B., B.S.Durh., Junior House Physician to the Royal Infirmary, Newcastle-on-Tyne.

Norton, J. J., L.R.C.S., L.K.O.C.Irel., Medical Officer for the Alrewas Sanitary District of the Lichfield Union.

Rowland, Frank, L.R.C.P., L.R.C.S.Edin., Resident Surgeon to the Birmingham General Dispensary.

Scott, Norman E. H., M.B., Ch.B.Glasg., House Physician to the North-Eastern Hospital for Children, Hackney.

Simpson, Wm., M.B., B.S.Durh., Senior House Physician to the Royal Infirmary, Newcastle-on-Tyne.

Young, A. G., M.B., C.M.Glasg., Medical Officer for the Castle Bytham Sanitary District of the Bourne Union.

Births.

CALTHROP.—On January 10th, at Fernbank, Cross Hills, Yorkshire, the wife of Gordon Calthrop, M.B., B.C.Camb., of a daughter.

COOPER.—On January 14th, at 20, Belsize Road, Hampstead, the wife of Ernest F. Cooper, M.R.C.S., of a son.

DODS.—On January 8th, at 24, Marylebone Road, London, N.W., the wife of Louis F. Dods, L.S.A., of a daughter.

LOWSELY.—On January 10th, at 36, City Road, London, the wife of L. D. Lowseley, L.R.C.P., M.R.C.S., of Hampstead Norris, Berks, of a son.

SANDERS.—On January 6th, at Villa Nina, Cannes, the wife of Gordon Sanders, M.D., F.R.C.P.Ed., of a daughter.

Marriages.

ROGER-SMITH-WOODD.—On January 10th, at the parish church, Old Hollington, near Hastings, Hugh R. Roger-Smith, M.D., M.R.C.P., third son of Professor Roger-Smith, of University College, London, to Dorothy Eugenia, third daughter of the late Rev. Basil R. Woodd, Vicar of Bilton, Harrogate.

WATSON-BARRETT.—On January 3rd, at St. Luke's Chapel in Norwich Cathedral, Charles R. Watson, M.D.Bru., of Tunbridge Wells to Grace Elspeth, daughter of Rev. Canon Barrett, of Lincoln.

Deaths.

CULLEN.—On January 4th, at his residence, Cheltenham, Deputy-Surgeon-General David Cullen, Army Medical Department, retired.

GRANT.—On January 3rd, at 3, Connaught Square, Hyde Park, London, Alexander Grant, F.R.C.S., Surgeon-Major, late of the Bengal Service, and Honorary Surgeon to the Queen, aged 82,

The Medical Press and Circular.

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Original Communications.

THE CO-RELATION OF SEXUAL FUNCTION WITH INSANITY AND CRIME. (a)

By H. MACNAUGHTON-JONES, M.D.,
M.A.O., M.Ch., &c.,

President of the British Gynaecological Society.

IT is customary for the outgoing President to make a few observations on some topic of gynaecological interest before leaving the Chair. I am influenced in the selection of the subject I am about to bring before you as much by the feeling that the operative side of gynaecology has been so frequently before us of late, that we may well divert our attention to a brief consideration of a gynaecological matter of interest which has nothing to say to operative methods and technique. I refer to the co-relation existing between the discharge of sexual function in women, mental alienation and criminal acts, as also to the bearings of gynaecological knowledge on a few important questions in forensic medicine. Here I must premise that our knowledge of the phenomena that correlate the functional activity or abeyance of action of the female sexual organs, with either transitory or permanent psychical consequences, especially those of a morbid nature, is not sufficiently definite to enable us to draw very accurate conclusions, or to formulate precise axioms, on which we can found principles of practice. On the other hand, experiences have been accumulating which offer most valuable suggestions in regard to the attitude which has to be taken to women at certain periods of their active sexual life, and which also help us by throwing a side-light on the many reflected nervous disturbances in organs remote from the sexual centre.

We may thus, not without profit, reflect on these points. How far does the process of menstruation, including in that term the physiological changes that take place in the ovaries and Fallopian tubes, as well as those which, either associated with, or apart from these, occur in the uterus, affect a woman, by originating morbid impulses in the various groups of her pelvic nerves which find their response in reflected neuroses in other organs, and thus influence the coherence and stability of her mental acts? Or again, in what directions, and to what extent, does the normal fulfilment of ovulation with menstruation develop for the time being erotic impulses, encourage the state of neurosis generally, or so lower both the psychical and physical inhibitory control as to lead to a hyper-exaltation of the nervous system generally, with increased susceptibility to slight irritations (from whatever source they may arise), and a weakened will control that permits of distorted mental visions and erratic moral acts, vulgarly called

crimes, that the woman is helpless to evade or to subdue?

In order to see to what extent this is true, we have to inquire whether there be evidence that menstruation, both normal and abnormal, does so influence the woman, and under what condition it is most likely so to do. The second division of the subject brings us to a very different question, and that is, how far disease of the sexual organs in women is co-related with symptoms of alienation from slight interferences with their mental equilibrium to more profound disturbances such as melancholia, dementia, or mania. This investigation naturally leads to the further inquiry, how far removal of the diseased organs by operation is salutary or otherwise to the woman, and to what extent the operation in itself may mitigate on the one hand, or, on the other, increase the mental trouble.

There are incidental matters connected with anomalies in the formation of the genitalia in women which have a bearing both on gynaecology and psychology, and which have also to be considered in looking at a case from the point of view of a student of forensic medicine. Lastly, there are a few questions of grave import in the elucidation of criminal acts, in the fixing of indisputable guilt, or in the protection of the innocent. Here, again, gynaecologists are brought into close touch with medico-jurists, and the responsibility is a grave one, for there are certain pathological points that the expert gynaecologist is the most fitting person to give a decisive opinion upon.

Before speaking on the questions to which I have referred, there are, it is necessary to remind you, two lines of thought which we should follow in approaching the question of sexual function in the rôle of insanity or crime. In the first place, we now know the intensity of the physiological function discharged not only by the ovaries, but by the Fallopian tubes and uterus, before a menstrual act is completed. In healthy women there is a cycle of changes in the round of which we have a series of nutritive processes, elaborated through the healthful interchange of function on the side of the circulatory current on the one hand, and the tissue and nerve-elements on the other. These processes cause alterations in the circulation of the Fallopian tubes, and the quantity of blood that they contain; the extraordinary changes which take place during ovulation in the ovary, resulting not only in the maturation and bursting of the follicle, but in a general enlargement of the organ and increase in the size of its blood-vessels; these phenomena being associated with, and followed by, equally marked changes in the uterine endometrium, and, in fact, in the entire uterus. All these alterations occur with a periodicity, and such slight outward evidences of their progress and completion, that there is no other physiological process of equal magnitude attended by such important pathological changes as those of ovulation, and yet so slight an apparent constitutional systemic disturbance.

(a) Valedictory Address delivered to the British Gynaecological Society, January 11th, 1900.

Also, we must remember that ovulation occurs independently of menstruation, and *vice versa*, and that even rhythmical menstruation may occur without ovulation; Pflüger, adopts the theory of a dynamic equilibrium of all the organs, from which it follows that the ovaries carry daily a definite number of stimuli to the central nervous system. At any rate, it is certain that the process of ovulation may go on quite independently of menstruation, and that, in fact, a period of about two days generally intervenes between the bursting of a follicle and the latter.

During all these changes in the genitalia there is a co-existing excitation of the ovarian nerve, causing reflex excitations in the uterine arteries, and, as Rohrig says, such ganglionic and nerve excitations proceed through duly provided paths. (a)

Experiments have shown how important is the effect of the secretion of the ovarian gland on the entire economy, and its normal metabolism. It would seem from the experiments of Curatullo and Tarulli (b) that, if it be suppressed the elimination of phosphorus is diminished, as also the respiratory changes are seriously influenced, while, owing possibly to a faulty metabolism, the body weight is increased. How great an effect the ovaries must have on metabolic phenomena, is, perhaps, best shown by the cure of osteo-malacia by oöphorectomy, an affection which Fehling has attributed to exalted ovarian functional activity and consequent reflex effects on the vasodilators and constrictors of the medulla. (c) The disease is, according to him, a reflex tropho-neurosis of the skeleton, having its focus of reflection in the ovary. Schauta and Mary Dixon Jones (d) have also recorded cases of cure of osteo-malacia by removing the ovaries, and the physiological effects of the constant pouring into the system of this secretion, is, according to Fehling, increased oxidation of organic phosphorised bodies, as well as hydrates of carbon and of fats. If, therefore, the ovaries are removed, or if their function is in abeyance, organic phosphorus is retained, and there is an increase in the calcareous salts in the skeleton. To follow up the various bearings of these physiological effects of ovulation, and the ovarian secretion, either through undue activity or diminution in quantity, would in itself occupy all the time at my disposal. Even the little knowledge we possess of the powerful effects of the unstable phosphorus compounds of the protagon and lecithin series on metabolism throughout the entire body, but more especially on cerebral, cerebro-spinal, and sexual impulses and excitations, is sufficient to indicate how great must be the influence of a secretion like that of the ovary on the entire nervous system, from the parts involved in the excitation of lower and higher reflexes to those portions of the brain cortex in its anterior lobes, which have, as Clouston says, "mentalisation as their function, and which are unquestionably the examples of the highest evolution of organised matter to be found in nature, the fullest of hereditary qualities, the most powerful, yet the most unstable, and by far the most physiologically valuable, part of man—the vehicle of the goodness of the saint and the badness of the criminal." Curious fact for reflection, that, as Hinton long since pointed out, where all this evolution of thought and will exists, there is no textural scaffolding, instability of structure having for its counterpart instability of organic material, and ever fleeting, changing, and mystic mentalisation, acknowledging no definite or stable scheme for its elaboration of the mandates that it issues.

(a) Paul Strassman on Ovulation. Archiv. f. Gynäk. Bk. 52., Ch. I. 1896. See summary by J. Taylor and Fredk. Edge. "British Gynaecological Journal," p. 2, Vol. xii.

(b) Annali di Ostetricia Ginecologia, October, 1896.

(c) "British Gynaecological Journal," February, 1897.

(d) "Oöphorectomy in Diseases of the Nervous System." By Mary Dixon Jones. Brooklyn, N.Y.

Also worthy of reflection is the fact, that while in the organs endowed with the highest vitality for sexual function and on the parts concerned in generation and the propagation of the species, we find this instability of organic constitution in the male and female secretions, so do we find the same organic instability in the constitution of the highest centres in which reside thought and will.

"There is no doubt," says Claye Shaw, (a) "that the sexual is an innate faculty of the brain stronger in some than in others, and one whose existence is possible without any correspondence of external organs." If this be true, then how much of sexual crime has its origin in defective or abnormal mental organisation?

This brings us to the recognition of all that mass of work which has been done of recent years, and which has served to prove that physical configuration, deviations from the normal physical type, evidences of defective evolution in the growing youth, combined with the legion of hereditary transmissions in which we have defective evolution, physical and mental, exist in one direction, while concurrently there appears to be an excessive distorted or diminished hyper-development of certain traits and configurations in the other.

If the researches of the school of Lombroso and his workers be true, and that physical configuration, not only in the higher centres of nerve structure, but in co-related physical deviations from the normal type, are indications of perversion in the moral and mental attributes of the person exhibiting them, how likely is it to be equally true that anomalies in development, and structural straying from the normal type, as well as pathological changes occurring in the sexual organs of a woman (organs from which emanate impulses and excitations, stirring the deepest depths of her moral nature), have a direct relationship to those motives and actions which we so flippantly embrace under the head of "criminal." If one of our duties as gynaecologists be to study the correlations that exist between the correct discharge of functions on the part of women's sexual organs, and the various morbid impulses set in motion, both physical and mental, arising from congenital or acquired histological and pathological changes in her sexual organism, including the many paths of sexual expression and impression involved by these, then, surely, gynaecologists are brought into the closest relationship with the springs of action which must throw light on criminal motives and criminal deeds.

"If," says Clouston (b), "we take the twelve years between thirteen and twenty-five as the average period of adolescence, it is in the latter six that most criminals develop into that condition. The maximum of criminality falls after twenty-five. By far the greater part of the habitual criminal become so, in fact, before the moral inhibitory faculties have attained full physiological perfection." And he goes on to say, "There is one kind of temptations then strongest, and these are connected with the sexual natus." It is at this age of life, as he insists, that criminals become so, while there is lack of development in their cerebral qualities, their intellectual, and their reasoning powers. This deficiency is associated in those centres, where, while in their highest form of development, we have instability in function and an apparent lack of textural homogeneity, there is still that mystic yet harmonious union of mental impulses with moral inhibition.

"Each with each in turn blending,
Each on each in turn depending."

"(a) On Insanity with Sexual Complications." By T. Claye Shaw, M.D. St. Bartholomew's Hospital Reports, Vol. xii.

(b) "The Developmental Aspects of Criminal Anthropology." By T. S. Clouston, M.D. P. 221.

that marks the moral and mental stability of the man or woman.

I have to abandon all idea of statistics in a short paper like this, and must be satisfied with referring to certain proved and established facts which bear on the relationship that exists between anomalies of development and pathological changes in the sexual organs of women, and perverted mental and moral impulses.

In the first place, we find such minor troubles present in a large proportion of women who have pathological changes in the uterus or adnexa, associated or not with congenital irregularities or deformities in conformation, as aggravated headache, sense of distension in the head, interferences with memory, facial neuralgia, migraine, ocular and laryngeal, with aural vertigo and tinnitus, symptoms of hyperæsthesia or anæsthesia of the extremities, spinal irritation, true hysteria, insomnia, anosmia or perversions of smell, general neuroæsthenic conditions as agorophobia, cesophageal spasm, gastralgia, and such a neurosis of the coccygeal nerves as painful sitting. Disturbances of the pneumogastric and splanchnic nerves are shown by gastralgia, with various dyspeptic symptoms, while the disturbance of the nerve control of cardiac rhythm finds its expression in intermittent or exaggerated action of the heart and dyspnoea. Such conditions we may class under the general head of visceral and various reflected neuroses, which owe their origin to perverted impulses starting from abnormal or diseased states of the genital organs.

Graver consequences are noticed in epilepsy and hystero-epilepsy, in melancholia, suicidal insanity, and dementia. Piqué found a proportion of 88 per cent. of gynecological affections among the insane, and others have found them in even higher proportion than this. He arranged his statistics from sixty six cases, according as the disease of the brain developed contemporaneously with that of the womb, those with serious genital affections, where operation had but a comparative success, and those whom operation benefited, hastening their recovery. There was definite cure in eleven cases.

We can hardly doubt, with A. T. Hobbs, that constant irritation of the lower nerve centres, incidental to local disease, must react upon the higher centres, and the effects recorded by several observers have to be given due weight in the consideration of the question as to whether insanity has been cured by the ovarian secretion. I have had some interesting evidence from Christopher Martin in the same direction, and Arthur Wilcox has treated several cases of insanity by the administration of ovarian extracts. In cases of suppressed menstruation, in which this was given, distinct recovery took place from such conditions as melancholia and mania. It was not so successful in epilepsy. Jacobs of Brussels has reported similar cases. Hobbs further found that one-sixth of the females in the Ontario Asylum suffered from diseases of the generative organs. Of 110 cases operated upon, 65 were either completely restored (36) or improved by operation (29), and the cases published by Holmes of Chatham (Ontario), Burgess of the Protestant Hospital for the Insane at Montreal, and many other writers, establish the fact of the correlation that exists between diseases of the pelvic viscera in women and insanity. If we look into the nature of the affection most likely to produce mental disturbance, we find it most common in disorders of menstruation, which of course may have as their cause various pathological conditions. With amenorrhœa and dysmenorrhœa we frequently find abnormal congenital configuration of the uterus and affections of the ovaries and Fallopian tubes. The affection of the ovarian nerves which Mary Dixon Jones has so accurately described as "gyroma," she

has demonstrated to be present in many cases of epilepsy, and the removal of the diseased ovaries has effected a cure in several cases not only of epilepsy, but of osteo-malacia. There are instances on record in which tubercle, carcinoma, and endothelioma were present in the removed organs. While time does not allow any lengthy reference to a record of cases, the names of the writers are sufficient guarantee in themselves of the reliability of their facts. They have shown that insanity and ovarian disease not only do frequently exist side by side, but that removal of the offending organ relieves the mental condition. Boldt, Felding, Goodell, Beatty, T. G. Thomas, Marion Sims, and Lawson Tait were among the earliest workers in this field. Still, the difficulty exists of establishing the relationship between uterine and adnexal disease and insanity as one of cause and effect.

Kraft Ebbing (a) has entered into a full investigation of the medico-legal relations of disordered menstruation, and he lays down the propositions that in any medico-legal investigation, not only should the mental condition of the woman during her menstrual period be closely investigated and the concurrency of menstruation with the act imputed be noted, but the previous history of her mental attitude during menstruation should be inquired into, and if it be found that menstruation has, as a rule, a decided effect on the ideation of the woman, or that the catamenial epoch be associated with mental disturbance and acts of an impulsive character, these facts should be taken into consideration as extenuating circumstances or the proof of irresponsibility. All evidence goes to prove that the appearance of the catamenia has, in a large number of the mentally afflicted, an important effect on their condition. This, of course, is more manifest in the disorders of the menopause, in which nervous excitations and psychic disturbances, with various hystero-neuroses, occur. And we know that, in addition to the ordinary histological changes in the ovaries and Fallopian tubes which takes place at the climacteric, there are also at this period frequent pathological changes both in the adnexa and the uterus.

A most valuable paper touching on this subject, on "Insanity with Sexual Complications," has been written by Clay Shaw (Bartholomew's Hospital Reports, vol. xxii.), and is well worth perusal by every gynecologist. He rightly dwells on the dual nature of sexual delusions—those that are purely mental, without relation to the sexual organs, and those which have their origin in the latter. He also points out how, even though there be a correlation between the insanity and the sexual centres of the cord, how dangerous it may be at certain times to excite further reflex activity and stimulate those centres. There may be, he says, uterine or ovarian disease without insanity, or a sexual form of insanity without disease of the genitalia, or, thirdly, insanity may exist and no sexual delusions. The great difficulty lies in establishing the cause or effect of sexual disorder and the insanity. It is clear that the mere fact of sexual acts or delusions being present is totally insufficient to do this, and the whole of Clay Shaw's arguments go to prove how difficult, if not well-nigh impossible, it is to establish such causal relationship. Referring to a case in which there were recurrent exacerbations of insanity during the catamenia, the patient being rational on most subjects in the intervals, though of an erotic nature, he says:—"I think that the operation of oöphorectomy would have much relieved her symptoms, at any rate, the violent ones; but of this I could not be sufficiently sure to be able to recommend it. . . . In an acute stage of violent

(a) "British Gynecological Journal," May, 1898.

insanity, anything like a serious operation is," he says, "out of the question, and there is always the probability of acute symptoms coming on after an operation, preventing the rest which is so indispensable. I think that this is just such a case in which an examination in the middle of the interval be justifiable, and if diseased adnexa were found, oöphorectomy should be performed; not otherwise. Seeing the mass of intellectually sound women who suffer from disease of the sexual organs, I think Clave Shaw's conclusion, that true sexual or uterine and ovarian insanity is by no means common, is a correct one; but, on the other hand, this does not invalidate the soundness of the proposition, that a differential diagnosis of insanity in women and the presence of disease of their sexual organs, has to be carefully considered as a primal or sustaining cause of the mental condition.

The expediency or justification for the examination of any insane woman will depend upon the answer to the question, not whether her insanity is sexual or otherwise, but if the assertion be true that the primary cause of the alienation may rest in a pelvic disorder, which it is the duty of those who have her in charge to discover. Dr. Clave Shaw speaks highly of the effect of wet cupping over the loins in cases of epileptiform insanity at the time of the catamenia. It has the advantage of directing the attention of the patient away from, rather than to, her sexual organs.

(To be concluded in our next.)

Clinical Lecture

ON THE

ROLE OF THE PHYSICIAN IN RENAL AFFECTIONS.

By PROFESSOR LANCEREAUX,

Of the Faculty of Medicine of Paris.

HAVING for function to eliminate from the economy the greater part of the products of tissue waste, many of which are extremely toxic, the kidneys play so important a part in the mechanism of life that if any serious impediment to their functions supervenes, the immediate result is poisoning and death. Consequently the physician should always bear in view the way in which these organs fulfil their function, not only in the course of affections peculiar to them, but in all maladies both acute or chronic for there are very few of the latter which do not, in one way or another, affect the kidney. In every case, then, and under all circumstances, the physician finds himself in presence of two special indications which never vary:—

Treat the renal lesion or functional trouble,

Treat the intoxication which is the consequence of the affection.

We will leave on one side traumatism, parasites, and tumours of the kidney, and even acute idiopathic nephritis. Every variety of nephritis, all these complex groups of symptoms which have been classed in general under the term Bright's disease, albuminuria, acute or chronic, are always symptomatic. Always and invariably, the primary malady localises its effects at the outset to one only of the anatomical elements composing the kidney. In fevers for instance, the epithelium alone suffers. In tertiary syphilis, saturnism and herpeticism it is the vascular connective tissue which is affected, the cells only becoming involved later on.

Hence we have two classes of nephritis, epithelial and connective tissue, which differ from each other in respect of their symptoms, their evolution, and their prognosis. This is the point which I wish to discuss on the present occasion, for this anatomical duality necessarily entails a therapeutic duality

Consequently, when called upon to treat a renal affection the physician must first ascertain the exact nature of the disease before venturing on a prognosis and employing a rational treatment, that is to say, the treatment proper to the histological element affected. Thus, in epithelial nephritis where the detached epithelium obstructs the ducts, causing almost complete suppression of urinary secretion, cantharides, which acts as a specific on the epithelium, incites the flow of urine after all other diuretics have failed. But you must bear in mind also that a rigid milk diet in these cases is of paramount importance, not only by reason of its diuretic effects but also on account of the necessity of not overtaxing the secretory function of the renal epithelium.

Let us consider on the other hand, connective tissue nephritis or nephritis without primary lesion of the epithelium. The indication is for us to have recourse to an agent capable of modifying the new sclerosed tissue. Preparations of iodine, and iodide of potassium in particular, possess this property. They should consequently be prescribed whenever the connective-tissue stroma is in process of proliferation. The drug should be prescribed in doses of from 15 to 30 grains daily and even more, and that for weeks, months, and even years on account of the tenacity of the affection. Employed at the outset, iodide of potassium sometimes effects a cure, but in the majority of cases the action of the drug is limited to retarding the progress of the disease. Prescribed when the disease had reached an advanced stage, the iodide does more harm than good. But this is not all. In addition to the two kinds of nephritis already described, there exists a third variety in which the structure primarily affected is the nervous element, viz., the so-called neuropathic affection of the kidney. In this malady, opium, antipyrin, and especially quinine should constitute our treatment.

When, in the course of these renal affections, uræmia has set in, the treatment naturally changes, and here also it is necessary to bear in mind the teachings of pathological anatomy and of clinical observation. What does pathological anatomy tell us? It tells us that the lesions of uræmia are focussed on the digestive tract. The other lesions of elimination, that of the skin, the bronchi, and the serous membranes, although present to a certain degree, are, however, not well marked; it is the alimentary canal which is principally affected. The mucous membrane of the stomach is injected, thickened, and sometimes ulcerated, and is always coated with thick mucus; the presence of this mucus produces irritation of the membrane, and is largely composed of the debris which can no longer pass off through the kidneys. The small intestine is but little affected, but it is otherwise with the large intestine, and especially the rectum, which is slate coloured, thickened, covered with mucus, and, in parts, ulcerated.

What does clinical examination teach us? It teaches us that there are two kinds of uræmic symptoms—digestive symptoms and nervous symptoms. The digestive symptoms (vomiting, diarrhoea, &c.) are rather providential; they should be respected and even solicited. We must, therefore, prescribe emetics, especially in the uræmia of fevers. The purgatives must be of the drastic kind, that is to say, such as act more especially on the large intestine. The nervous symptoms (convulsions, headache, delirium, &c.) should be treated by chloral. Nothing equals chloral in the treatment of nervous uræmia, provided it is given in sufficiently large doses. Give it without hesitation and you will never have occasion to regret it.

Such are the general principles of the treatment of uræmia—drastics and chloral. There are, however, other means of treatment which must not be

neglected, one of which I may mention, for I employ it frequently, I am referring to cold affusions. Every morning I order the whole body to be rubbed with cold spirit lotion in order to stimulate oxidation. This treatment is vastly superior to inhalations of oxygen, which, after all, only occupy the mind of the patient, and can do no real good. After the administration of drastics (scammony, jalap, &c.) you have seen me prescribe pills composed of squill, digitalis, and scammony, in doses of one grain each of these substances. From six to eight of these should be given daily for six or eight days.

These pills purge two or three times a day, and increase the quantity of urine. They act rapidly, especially where much œdema is present. If, however, after three days the secretion of urine has not notably increased, the pills should be replaced by the bromide or caffeine.

The regime of the patient should be milk, but occasionally, tea and *café noir* may be permitted.

The Harben Lectures.

DIPHTHERIA.

By PROFESSOR WILLIAM R. SMITH, M.D., D Sc.,
F.R.S.Ed., BARRISTER-AT-LAW.

ABSTRACT OF LECTURE III.

DIPHTHERIA, as I have already remarked, is a disease occasioned by the presence of a particular bacillus, which for all practical purposes is found alone in the affected area and its neighbourhood, and which in the course of growth and multiplication forms a toxin, or poison; and this poison, subsequently becoming absorbed into the system, gives rise to the general symptoms with which we are all familiar.

These toxic products are therefore of the greatest importance. They vary greatly in their composition, and consequently differ in what may be called their lethal activity, and in their local or swelling-producing activity, one specimen containing a considerable proportion of the substance which determines the local effect, but a smaller amount of the substance causing the death of the animal; whilst a second toxin may set up only a slight local reaction but cause death in a comparatively short space of time. In diphtheria it is the lethal action of the poison which has to be reckoned with, and, in the successful treatment of the disease, therefore, the activity of antitoxic serum is determined by ascertaining its power of neutralising this lethal activity as accurately as possible.

In order to determine the absolute toxicity of a toxin Ehrlich took the death period as four days from the day of infection, so that if the animal lived beyond the fourth day, the dose of toxin would be considered sub-lethal. He pointed out that, owing to the varying susceptibility of the animals, the dose might kill some of them in two days, while a certain number of them might live to the fourth day, but if the dose were strong enough, no animal should live beyond that day. Theoretically 100 times this dose, injected along with one unit of antitoxin, should not kill before the fourth day, on which day the animal might die, but it certainly should not live beyond the fifth or sixth day. It was found, however, that this multiple of 100 plus the unit of antitoxin did not give these definite results. He then determined accurately two neutralisation points—first, the amount of toxin which one antitoxin unit exactly neutralises—i.e., the effect on the animal after injection would be such that not only would the animal not die, but no ill-effects would follow. This point he represented at L_0 , nothing being left to be neutralised. The second neutralisation point was that at which the quantity of toxin present is not only sufficient to neutralise the whole of the antitoxin, but a sufficient quantity of uncombined toxin remains sufficient to kill the animal on the fourth day—

this point he represents as L_x . Theoretically the difference between the two L_0 and L_x should be 100 and 101 multiples of the single dose respectively. In the first case there is complete neutralisation, in the second an excess of toxin sufficient to kill the animal in the same time that a single lethal dose would bring about the same result. This method, however, is not in actual practice.

Ehrlich further shows that there is a definite chemical action and reaction between toxin and antitoxin, neutralisation going on more quickly in concentrated solutions than in diluted ones. Heat accelerates and cold retards the combination, and these, it will be noted, are precisely the conditions under which ordinary chemical double salts are formed. He thus was led to look upon the neutralisation of toxins by antitoxins as the formation of a double salt; and arguing from this analogy, he laid down the rule that one equivalent of the toxin always neutralises an equivalent of the anti-substances, and that multiples of the one neutralise corresponding multiples of the other. A molecule of the toxin binds, therefore, a definite and constant quantity of the anti-substances, for which also it has a specific affinity.

A further suggestion by Ehrlich, which is of supreme interest in this connection, is that small quantities of the tetanus toxin are actually selected by the motor ganglion cells of the central nervous system from the fluids in which the toxin is conveyed throughout the body, and firmly held by such cells. Every functional cell consists primarily of a nucleus, associated with which is the main function of the vitality of the cell. In addition there are associated "lateral chains" with subsidiary or special functions. These chains have specific combining functions, one chain especially having a special affinity for the tetanus poison which is literally seized upon by the living protoplasm of the cell, and by this means the lateral chain is subjected to the continued influence of the attached tetanus poison, which—to use Ehrlich's words—"brings about a slowly-advancing, but long-continuing functional disturbance so long as the union of the lateral chain and toxin continues," and this union generally remaining permanent, there is an explanation of the formation of the anti-substances.

This function of the lateral chains to hold the toxin is something apart from the ordinary cell activity. As fresh toxin is presented, so there is induced in the cell a greater and greater power of combining with the toxin, this power assuming a particulate character according as the toxin molecule is that of diphtheria, tetanus, snake-poison, or the like, and as fresh supplies of toxin are provided, new lateral chains are formed, having the specific power of combining with the specific toxin. These chains become developed to such an extent that they can no longer be retained in the cell, but are thrown off into the blood unused, ready to come into contact with the specific molecules for which they have affinity—indeed, under such circumstances they appear to have a greater power of combination than they possessed when present in the cell.

Another interesting point is that even large doses of the toxins, with the exception of the snake poison, require a considerable time in which to exert their toxic effects. Ehrlich suggests that this is because the toxin is forming a definite molecular combination with the protoplasm of the cell or its lateral chain, and that having entered into the combination, it does one of two things, either it paralyses the cell, thus interfering with its main functions, or it so stimulates its special function that, in place of succumbing, it gradually acquires the power of combining with, and rendering harmless larger and larger doses of toxin. In the one case, the death of the cells and the animal occurs; in the other the formation of antitoxin.

Further, Ehrlich asserts that if the special cells of an animal or organ do not possess lateral chains that can unite with the toxin molecule, the toxin does not prove fatal to these cells, and no antitoxin is produced. The obvious bearing of this upon the production of antitoxin by susceptible animals, and the failure of all attempts to reproduce it in animals immune to certain of these organic poisons, is of great interest.

Roux and Yersin obtained the toxin of diphtheria by precipitation with alcohol and phosphate of lime, and therefore looked upon it as a ferment or an enzyme, Brieger and Frankel saw in it a tox-albumin or a mixture of such, whilst Dr. Sidney Martin, in a report to the Local Government Board (on "The Chemical Pathology of Diphtheria and of Infective Endocarditis; with an Account of Diphtheria Palsy, experimentally produced by the Chemical Poison of Diphtheria"), describes how he obtained an albumose and an organic acid from the blood and organs of patients who had died of diphtheria. This albumose is capable of remaining in the blood for a considerable period after a single injection.

If such a toxin be kept in a warm chamber, it begins to lose its toxic effects, while its power to neutralise an antitoxin remains unimpaired. This is an important fact to remember in keeping a test toxin for standardising an antitoxin.

Further, Dr. Cartwright Wood, who had previously pointed out that, in order to artificially obtain the toxins of the microbe formed in the human subject, it was necessary to give it albumin, so as to place it as nearly as possible under analogous conditions to that which pertained in man, obtained an active growth of the bacillus by inoculating broth with a virulent culture, and after the lapse of a day or two he added 10 to 20 per cent. of horse serum, or plasma, in order that the enzyme or ferment toxin produced from the broth might not alone be formed, but also the albumoses from the dilute albumin.

The conclusions which Dr. Cartwright Wood arrived at as the result of this interesting series of experiments with albumoses may be given at length, so important are they in connection with the treatment of diphtheria. They are: "(1) That powerful diphtheria antitoxins can be produced without risk in a much shorter period of time than has been previously possible; (2) that much more powerful antitoxins can be easily produced, so that the amount necessary to be injected into a patient can be greatly reduced, and one of the great objections to its introduction into private practice in this country may be removed; (3) that the greater strength of the serum will permit of the patient receiving at the beginning a sufficient quantity of the serum at one injection, when, as is universally recognised both by animal experiment and clinical experience, its curative action is exerted most markedly."

After these preliminary remarks let us now consider the steps necessary for the preparation of antitoxic serum. The toxin is prepared by the growth of the diphtheria bacillus in nutrient bouillon, prepared by taking a pound of veal, from which all fat and connective tissue has been removed, mincing it, and adding to it 800 c.c. of water, allowing it to stand for two or three hours, and then boiling it for twelve hours, care being taken to keep the meat from running together in masses by shaking it; the fluid is then expressed from the meat in a press, and 2 per cent. of Witte's peptone added; it is afterwards boiled for an hour, allowed to cool, and filtered; it is then heated to the boiling-point, and neutralised or rendered faintly alkaline to phenol phthalein with normal sodium hydrate solution, about 30 to 33 c.c. of normal sodium hydrate solution being required per litre; after neutralisation it is again boiled for two hours, filtered, and transferred to the flasks in which the toxin is to be produced, which resemble a Wolfe's bottle, having three necks; this shape of flask so as to ensure a good surface growth, 400 c.c. of broth are placed in each flask.

The broth is inoculated with an organism, which has been specially chosen for its virulence, and the flask is kept at a temperature of 35 degs. C., or from 30 degs. to 36.5 degs., some bacilli producing a more active toxin at the lower, others at the higher, or at an intermediate, limit. In the course of twenty-four hours a diffuse cloudiness takes place in the liquid due to the formation of dust-like granules or small flakes, which sink to the bottom as a flocculent sediment. The turbidity and sediment increases in proportion to the activity and vigour of the organism; at the same time a film is

formed on the surface which is easily broken up by shaking, when it sinks to the bottom; the opalescence remains as long as the alkalinity of the medium is maintained and growth continues; when this has ceased, the flocculi sink to the bottom, the broth resumes its original clearness, and the formation of toxin ceases, although the bacilli are alive in the sediment; this film-formation is important as an indication of strong toxin production.

If the reaction of an inoculated alkaline broth be tested at intervals, an acid reaction will be noted which increases during the first two or three days after inoculation; then comes a pause, and finally the broth appears to regain its alkalinity; if the broth be acid or but faintly alkaline, no good toxin is produced.

The growth of the pseudo-diphtheria bacillus is also vigorous in broth, but the cloudiness is more dense, sets in earlier, and the broth becomes clear much later; there is also an absence of acid-production in the early days of growth.

The toxin is then poured into properly sterilised jars, where the bacilli rapidly settle in a thick deposit. The supernatant liquid is then at once filtered through a Chamberland filter, and the strength of the toxin, as regards its lethal activity tested, and the result recorded on the flask which contains it.

The antitoxin is obtained by taking a horse, and testing it for glanders and tubercle in the first instance by the use of mallein and tuberculin so as to be assured that the animals are free from these diseases. An injection is then made subcutaneously in the neck of 300 c.c. of the serum toxin; this, according to the amount of reaction obtained, is followed by a similar injection of 400 c.c. in two or three days, and so on persistently for about four weeks. In this way the animal is rendered immune, and then injections of the ordinary ferment toxin may be commenced, 400 c.c. being first used, and then repeated every three or four days, the doses being gradually increased until 500 or 600 c.c. are injected. The blood is carefully tested from time to time throughout the treatment, and in this way it can be determined when the blood is ready to be drawn. This is eventually done by making a small incision through the skin over the jugular vein; slight pressure should then be exerted on the vein below the point of intended orifice, and by thrusting in a trocar, to which is attached a piece of indiarubber tubing, this is arranged to discharge its contents into a sterile beaker of a capacity of 800 c.c., covered with parchment paper, and containing 6 or 7 c.c. of a 10 per cent. solution of citrate of soda. The addition of this salt delays the clotting of the blood, so that the red cells have time to fall to the bottom, by which means an exaggerated buffy clot is formed. At the end of twenty-four or forty-eight hours nearly one-half of the bulk of the blood is drawn off as serum, and if the clot be allowed to stand a day or two longer another 5 or 10 per cent. may be withdrawn. The serum is drawn off by a system of exhaustion into a sterilised conical flask, graduated in half-litres, and to each litre 30 c.c. of a 6 per cent. emulsion of trikresol is added, so as to make the serum an impossible medium for organisms to grow in. The serum in bulk is then transferred to a cool, dark room. No other special precautions are called for, it is then tested and brought up to a proper standard with other antitoxins of known strength, and ultimately sent out in small tubes containing 4,000 units in 10 c.c. for a dose.

The use of antoxic serum for the treatment of diphtheria cases has now for some time been general in the hospitals of the Metropolitan Asylums Board; let us therefore look for the results to the statistical evidence available from these institutions.

I have prepared tables showing the mortality per cent. of the diphtheria cases admitted into all the Board's hospitals for each year since 1889, the first complete year after diphtheria was recognised as a disease admissible to the Board's hospitals, from which we can deduce the following total mortality rates:—

1889	...	...	40.7	1895 (first antitoxin year) ...	...	22.8
1890	...	...	33.5	1896 ...	...	21.2
1891	...	...	30.6	1897 ...	...	17.7
1892	...	...	29.5	1898 ...	...	15.4
1893	...	...	30.4			
1894	...	...	29.2			

by which it will be seen that in 1898 the mortality had been reduced by the use of antitoxin nearly 50 per cent.

At every hospital the rate of mortality fell, the lowest being at the South-Western Hospital, where it dropped from 22.50 in 1892 to 11.96 in 1898.

We find that for every age-group the percentage mortality in 1898 was less than one-half of what it was in the pre-antitoxin period 1890 to 1893.

In a report issued by the medical superintendents of the Metropolitan Asylums Board for the year 1895, the following table appears, which shows the great importance of the treatment being adopted at an early stage of the disease; this we can readily see is in absolute accord with our scientific knowledge on the cause and progress of the disease.

Showing percentage of mortality in relation to day of disease on which cases of Diphtheria came under treatment in the Hospitals of the Metropolitan Asylums Board.

Day of disease.	Mortality per cent.
First	11.7
Second	12.5
Third	22.0
Fourth	25.1
Fifth and over	27.1
Total	22.5

This table is not repeated in the 1898 report.

The benefits derivable from early treatment are clearly shown in this table. But far more striking evidence is obtained from the experience of the serum treatment of post-scarlatinal diphtheria cases, that is, cases of scarlet fever which develop diphtheria whilst in scarlet fever wards. To such cases occurring in the Board's hospitals, the treatment can be applied immediately after the diagnosis of the disease.

From a consideration of the tables which I have prepared, it is manifest that the greatest success attended the treatment of those cases which were at once recognised, and at once subjected to the injection of antitoxin serum.

We have now arrived at the point where we may consider what, if any, practical points we have gleaned which may help us in dealing with outbreaks of this disease.

We naturally ask, how is its continuity maintained in the intervals between epidemics? Is it a sufficient explanation to give that the disease is kept alive by direct infection from one to another by so-called unrecognised cases, or is it not more reasonable to suppose that the germ finds some favourable local habitat such as soil, and that at intervals its virulence becomes increased and a fresh outbreak occurs? But if this be so, then our inquiry is thrown a step further back, for we then have to determine what is the cause of the periodic increases of virulence, or else, assuming there is no variation in virulence, what occasions an attack on human beings? All these questions involve problems of the greatest complexity, which will still further have to be worked out.

The chief cause of infection, so far as our evidence at present goes, is personal contact. Owing to the compulsory notification of disease in this kingdom, there is but little chance of a well-marked case of diphtheria remaining for any time as a source of danger to the community, but there is a danger of mild and unrecognised cases so remaining; such, for example, as when one member of a family has contracted diphtheria, and has infected the other members, these latter being to some extent immune, or has infected others before definite symptoms have arisen necessitating isolation; or,

secondly, among school children when a child has the specific organism in his throat, and infects others before definite symptoms have arisen; or, thirdly, when convalescent patients who have been treated in hospital, are clinically cured, but still retain diphtheria bacilli on their fauces, and are allowed to return to their families.

If it were insisted that no patient should be discharged till the throat were free from the specific germ, it would involve great hardship to the patient, and would put even a greater strain on hospital accommodation than is the case at present. The best thing would seem to be to send each patient, as soon as he was well enough, from the ward tenanted by acute cases, into the country if possible, or at all events into a different department of the hospital, and there, by means of abundance of pure air, aided by local antiseptic treatment, to see if the bacilli would not disappear in a shorter time than occurs in a diphtheria ward.

We have noticed the great incidence of the disease on young children, and the importance of school authorities adopting all proper precautions for the prevention of the spread of the disease through the agency of schools. I have reasons for believing that these are not so rigidly observed throughout the country as they should be, and it would seem desirable that the Education Department should take a more active part in directing school authorities in these matters than they have hitherto done. Questions of the most vital public health interest are continually arising in connection with the aggregation of children in schools, and it would appear a matter of urgent public necessity that for such questions the Education Department should have at its disposal the services of an experienced medical adviser. I know that this Institute has made representations on the subject to the Government, and these it is to be hoped will meet with a favourable response. But the measure of all others which I desire most strongly to urge is the use of diphtheria antitoxin for prophylactic purposes.

The only possible objection to the use of diphtheria antitoxin for prophylactic purposes is liability to the inconveniences occasionally attendant on the injection of the serum arising from the occurrence of rashes and perhaps joint pains. These are due not to the antitoxin, but to the serum itself, normal serums exerting a similar action, and, according to Behring, the smaller the amount of serum injected, the less is the risk of these symptoms occurring. The prophylactic dose, of course, requires only a very small quantity of serum, and Behring suggests that this ought to be reduced still more by the use of the extra potent serums, so as to obviate all risk of the occurrence of such symptoms. As these extra potent serums are not so stable as those of the lower grade, he suggests that they should be sent out in the dry form for this purpose. It is hardly necessary to state that the protection, where necessary (as in the case of nurses, attendants, &c.), can be kept up by repeating the injection every five or six weeks.

By the general adoption of this means, I am certain, the amount of diphtheria would be materially diminished, much suffering prevented, and we should be fast approaching the time when the disease would be altogether removed from our midst.

ON THE THERAPEUTIC VALUE OF SALOPHEN.

By T. POYNTZ WRIGHT, M.R.C.S.E., L.S.A.,
M.O.H.

THE value of salophen as a therapeutic agent in various diseases does not appear to have attracted the same attention in this country, or—till lately—in America, as it has on the Continent, where for some years past it has been viewed with great favour, and where, also, the best results have attended its exhibition in numerous ailments. I am desirous, therefore, of recapitulating some of the experiences that have been obtained from its use, and the nature of the cases treated, with a view to a more extended trial by the profession here.

I pointed out, in a letter addressed to one of the London medical journals nearly a year ago, that one of the principal advantages of salophen lay in the fact that it was a perfect substitute for salicylic acid, and its salts, and that one of its chief claims was that it possesses all the merits of the former drug, with none of its inconvenient after-effects.

It has long been recognised that the various preparations of salicylic acid are among the most reliable remedies for many diseases, but it is also equally recognised that the use of this salt and its compound when long continued, or when exhibited in large doses, frequently produce symptoms, such as vomiting, nausea, headache, buzzing in the ears, or even delirium, which often compel us to discontinue its use, and this before we have effected the object for which it was administered.

Salophen is a combination of salicylic acid and acetylparamidophenol, which is not decomposed by acid, and which passes through the stomach unaltered, and without disturbance. The intestinal alkaline mucus, however, splits it up into salicylic acid, and acetylparamidophenol, but the process is so gradual and slow that the effect of the salicylic acid on the system is much more lasting, and this without any of the disturbances previously referred to.

It is claimed for salophen that whenever salicylic acid is indicated salophen should be tried in its stead, and for the reasons above stated. This, of course, implies that salophen would be of value in such diseases as acute articular, chronic, and muscular rheumatisms, neuralgia, cephalalgia, sciatica, gout, influenza, scarlatina, and in certain cutaneous diseases; and such proved to be the case.

Taking the rheumatic and gouty class of ailments first, the experience of American and Continental physicians points clearly to the great value of salophen in acute articular rheumatism. In a paper by Dr. Richy, of New York on "A Therapeutic Study of Salophen," published in the *Medical Examiner*, October, 1898, the evidence as to its action is conclusive. Dr. Richy quotes Dr. Guttman, Dr. Hirschmann, and Dr. Frohlich, both of the Imperial General Hospital of Vienna, Dr. Lutze, Dr. Lange, Dr. E. Koch, Dr. Hardenbergh, Dr. B. H. Waters, of New York, and many others. The experience of all of these are that salophen relieves such cases more rapidly than the salicylates. Dr. Richy says:—"From a study of the literature on salophen in acute articular rheumatism it appears that the drug, whilst endowed indeed with all the properties of the salicylate of sodium, is completely devoid of its unpleasant after effects." Dr. Richy also calls attention to the efficacy of salophen in scarlatina, observing that it presents many symptoms and complications similar to those of acute rheumatism; it seems, therefore, reasonable to use salophen at the beginning of an attack of scarlatina, with the effect that the congestion of the throat rapidly subsides. Such a line of treatment cannot fail to favourably modify the course of the worst cases of scarlatina.

Cases of tonsillitis appear to have been treated with marked success by salophen, especially when connected with a rheumatic diathesis.

The author's experience of salophen in rheumatoid sciatica has shown it to be of great value.

As regards cutaneous affections, Dr. Radcliffe Crocker, in the treatment of psoriasis, has substituted salophen for salicylate of soda, in consequence of the disturbance occasioned by the latter drug. Dr. E. Wannemaeker, of Ghent, is also in favour of salophen in most cases of skin affections accompanied by itching, such as prurigo, urticaria, psoriasis, pruritus, and seborrhoeal eczema.

In the concluding observations of Dr. Richy's paper the following occurs:—"I would mention that salophen has also been employed with success as an antiseptic in intestinal affections. Dr. Hare considers it preferable to salol in the treatment of cholera. Dr. Caspar regarded it of value in typhoid fever, while Dr. Cuillini and Dr. Viti, as a result of experiments on animals, have established the fact that salophen acts as an anti-fermentative in the intestinal canal. Although I have no personal experience as to its utility in this class of disease, the evidence adduced in its favour is sufficiently strong to render it worthy of a careful trial."

I believe, however, that it is in influenza that salophen is more especially valuable, and in my letter previously referred to this was the point that I particularly desired to emphasise. A further experience of its use in influenza during nearly a year has but tended to confirm, more strongly than ever, the views that I then held, and, as this disease is now rife all over the Kingdom, it may be opportune to recapitulate to some extent my opinion. I then said "It is however as a specific for influenza that I desire now to call attention, and from the evidence adduced, there can be little doubt that salophen stands pretty well at the top of the list of all the reputed specifics for the cure of that disease."

"Dr. Hennig, when speaking of influenza, says that among the remedies applied for neutralising neuralgic pain, none have proved so efficacious as salophen, and he 'recommends salophen most cordially in the nervous forms in which influenza presents itself.' Dr. Goldschlager, of the Wieden Infirmary, Vienna, reports that he obtained 'some extraordinarily favourable results in treating influenza with salophen.' Again, Dr. Drews, of Hamburg, is still more emphatic. He states that 'the effect of salophen on the nervous forms of influenza is so favourable as to cause me to declare it, unhesitatingly, to be a specific for the nervous forms of influenza.' This statement with regard to its specific action is fully endorsed by Dr. Claus, of Ghent, and other physicians. In the face of this unanimous testimony as to the value of salophen, coming from men whose *ipse dixit* is above suspicion and incontrovertible, it is clear that we are in possession of a remedy that will help us in checking the ravages of this recent scourge to society."

In support of the above, and to quote more recently, Dr. Richy states that Dr. A. Claus "assigns to it a leading place among specifics for influenza," that Dr. A. Hennig "found no remedy so constant in action in influenza as salophen." He further states that Dr. J. M. Thompson reports that "he had better results in *la grippe* from salophen than from any other remedy."

The extreme prevalence of influenza, at the present time, affords a favourable opportunity for testing the merits or otherwise of salophen in this disease, and of showing whether the deductions arrived at by the profession, on the Continent and America, as to the value of the drug are fallacious or whether it is capable of bearing that impartial trial that those who believe in it are anxious should be extended to it.

Clinical Records.

A COMPARATIVELY RARE INJURY TO THE DISTAL PHALANX OF THE FINGER. (a)

By JOHN EWENS, L.R.C.P. Lond., L.R.C.S. Ed.,

Consulting Surgeon Royal Hospital for Sick Children and Women, Bristol.

I HAVE purposely introduced the word "comparatively" into the title, as, although I have not been able to find any description of the accident in any work of surgery within my reach, it is quite possible that others may have met with it more frequently than myself.

I do not remember having met with more than three cases, the first occurring three years since to a middle-aged woman; the second to a youth about 15; and the third to an officer in Her Majesty's Army.

In each case the accident was produced by the finger suddenly impinging with great force upon a hard immovable substance, and the ungual phalanx was bent forward as in a dislocation, but the ease with which the displacement was remedied, and with which it returned to its abnormal position, proved that this could not be. The pain following the accident was severe, and, on seeing the patient within an hour or two, there was great tenderness, pain, and swelling situated over the proximal end of the phalanx and the joint, with great heat of the surface. The pain was speedily relieved in great measure

(a) Abstract of paper read before the British Orthopaedic Society, December 16th, 1899.

by putting the finger in a proper position on a well-padded splint, reaching to the wrist joint, and kept there by narrow strips of plaster and bandage. Any attempt to leave off the splint gave great pain, and if allowed, the phalanx would have at once returned to its abnormal condition.

In the first two cases, which were under my own supervision, the splint was not removed for a month, when everything was found to be right, except that in Case 1 pretty severe neuralgic occasional pain came on, when the finger was used. This gradually subsided under application of tincture of iodine.

Case No. 3 I did not see till 8 months after the accident (about eight weeks ago), when I was consulted by the patient as to whether any operation could be performed to restore the normal condition of the finger. I found the phalanx could not be extended by the action of the tendon, and it was flexed to an angle of 40 degs. Great pain was often felt, and there was some swelling of the parts. I did not recommend an operation, considering that the division of and shortening the extensor tendon would involve greater risk than was justified. I therefore recommended painting with iodine, and using the finger at his discretion. The practitioner who was consulted applied a splint; but left it off in four or five days, and ordered passive movement, and this alternate treatment of splinting and movement had been continued ever since. When last I saw the patient, about two weeks ago, pain had subsided, and the joint could move freely, but I doubt whether the proper shape of the finger can ever be restored.

Now what is the nature of the accident? Evidently not dislocation for the reasons above stated. Neither is it likely the tendon itself could have been ruptured in the ordinary way.

I would suggest that either (1) the flattened and alternated termination of the tendon may be torn through close to its insertion into the phalanx; or (2) more probably the periosteum may be raised from the bone, thereby causing effusion of blood, and subsequent periostitis, thus accounting for swelling and severe pain. In either case perfect rest and careful adaptation of the parts must be maintained for certainly four weeks, and it is probably due to the neglect of these precautions, the patient (No. 3) owes, what will doubtless be, a permanent deformity. As he is an officer, although the injury, being the little finger of his left hand, will not interfere with his duties, yet for appearance sake any operation considered justifiable would be readily consented to.

Transactions of Societies.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD WEDNESDAY, JANUARY 17TH, 1900.

Mr. A. G. MILLER, President, in the Chair.

Dr. NORMAN WALKER showed a case of "acne varioliformis"; the condition was fairly typical, the scalp as well as the face being affected, thus differing from ordinary acne. Although the patient had improved under iodide there was no reason to suppose that the lesion was syphilitic.

Mr. MACGILLIVRAY showed a specimen from a case of fracture of the skull.

Dr. CHARLES BEGG read a paper on

CLINICAL EXPERIENCES WITH SALOL IN THE TREATMENT OF SMALL-POX.

His attention was first called to the action of this drug in subduing cutaneous irritability by observing a patient suffering from cystitis who was taking 15 gr. doses of salol three or four times a day. The man, a resident in China, was a martyr to mosquito bites; they usually caused such irritation as to lay him up completely, yet while taking salol (although he dispensed with mosquito curtains and was covered with bites) he remained comparatively immune from itching and dermatitis. Dr. Begg then began to use salol in various forms of irritable skin disease with decided benefit. He has employed it

in a number of cases of small-pox in China occurring both in Europeans and in unvaccinated natives. He found that it removed the irritation almost entirely, and prevented the scratching to which so many ill effects, such as sleeplessness, infection of the eyes, &c., were due. A most important consequence of treatment with salol was that the eruption did not pass beyond the vesicular stage—the vesicles did not mature. In an Englishman over 60 years old with severe confluent small-pox, who was treated with salol, only two groups of vesicles went on to suppuration. He recommended that salol be given in such cases in divided daily doses of one drachm, and had seen no bad results save a degree of mental depression. He ascribed the therapeutic action of the drug to the elimination by the skin of salicylic acid and phenol.

Dr. NORMAN WALKER concurred with the speaker as to the benefit given by salol and salophen in cases of irritable skin disease. Salol, rather than arsenic, was probably the most useful all-round drug in the possession of the dermatologist. The pitting in small-pox was largely caused by the pressure of scabs which were allowed to dry; if they were kept moist, so as not to contract, scarring would be greatly lessened. He asked whether Dr. Begg had any experience of the red light treatment of small-pox. Dr. Harvey Littlejohn also spoke, and Dr. Begg replied.

Mr. SHAW McLAREN read a paper on

PERMANENT DISLOCATION OF THE PATELLA.

Such cases were not common; the dislocation was usually to the outer side, the leg being everted and the anterior surface of the patella directed externally. As a rule the affection first attracted attention after a slight injury to the knee by a fall; it was rarely congenital. In examination of the records of previous cases he found that the following conditions had been said to be associated with dislocation:—1 knock-knee; 2. dislocation at birth; 3. synovitis; 4. defective development of the external condyle; 5. mal development of the patella; 6. permanent external rotation of the leg. In his case the patient was formerly the subject of rickets, and had well-marked genu valgum of the right leg. Both legs had been knock-kneed in childhood, but the left had spontaneously recovered. The right leg was permanently rotated outwards, and there was defective development of the external condyle of the femur, the patellar surface of the bone being narrow, the ridge on the external condyle absent, and the condyle itself abnormally rounded from side to side. He decided to operate, and did a preliminary osteotomy to connect the genu valgum. Thereafter he moored the patella by strong silk sutures to the aponeurosis of the vastus internus. The convalescence was very protracted owing to wasting of the rectus femoris and consequent loss of power, but in the end the patient got an absolutely useful limb, and now, four years after the operation, showed no trace of recurrence.

Dr. HARVEY LITTLEJOHN read a paper on a case of

MURDER AND SUICIDE BY CUT-THROAT.

The bodies of a man and a woman were found lying in an hotel bedroom. The woman was lying across the bed with her feet on the floor, dressed in her out-door clothes, with thick jacket and gloves on, only her hat having been removed; the man lay face downwards across her body. There was a single clean-cut wound in the throat of the woman extending from the symphysis menti to the angle of the lower jaw, the left internal jugular vein having been completely divided and the bodies of the vertebrae scored by the knife. In the man's throat there was a series of cuts extending from the left angle of the lower jaw to past the middle line. A blood-stained razor lay close to his right hand, which was also blood-stained. In such a case the possibilities were double murder, double suicide, and murder and suicide. The last-named alone accorded with the facts; the wound in the throat of the woman was single, a clean, deep cut, dividing part of the collar of the jacket; there was no blood about the room or on the front of the woman's dress or on her hands, and from this it appeared that she was probably thrown suddenly backwards while resting on the edge of the bed, and had been murdered before she had had time to cry out or struggle. The wound of the man's throat was evidently

self-inflicted, as shown by its direction and multiple character, as well as by the blood stains on his hands, and the position of the razor.

BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD JANUARY 11TH, 1900.

The President, Dr. MACNAUGHTON-JONES, in the Chair.

ANNUAL MEETING.

THE Treasurer, Dr. MANSELL-MOULLIN, having read his annual report, which was of a most gratifying nature, Mr. STANMORE BISHOP, of Manchester, moved its adoption, and a cordial vote of thanks to the treasurer for his services to the Society.

This having been unanimously adopted, Dr. HEYWOOD SMITH moved that a cordial vote of thanks be passed to the retiring officers for their great and untiring services. He referred especially to the President, Dr. Macnaughton-Jones, in whom the Society had shown its confidence by electing him a second year to fill the chair, and whom he characterised as a model President, courteous, hospitable, and most able in the discharge of his duties. He also specially mentioned the good work of the retiring secretary, Dr. G. E. Keith. The vote was seconded by Dr. DOLAN, of Halifax, and carried unanimously.

After the transaction of the business of the annual meeting, the retiring President, Dr. MACNAUGHTON-JONES, delivered his Valedictory Address on "The Correlation between Sexual Function, Insanity and Crime," which will be found in another column. He concluded his remarks with a brief review of the losses sustained by the Society during the past year.

Dr. C. H. F. ROUTH moved a hearty vote of thanks to the President for his valuable and interesting address. They had been regaled by a wonderful paper; but in view of the fact that this was the last address they would hear from Dr. Macnaughton-Jones, from the Presidential chair, he wanted to speak not so much about the paper, but rather of the man. He wished to thank him for the courtesy, hospitality and impartiality which had characterised his tenure of office, and for the learned and valuable contributions which he had made to their debates. Among the many distinguished past occupants of the chair, none had been worthier, or better fitted for the post. While many good qualities distinguished the natives of Great Britain, the true Irish gentleman was above all distinguished for the quality of heart, and Dr. Macnaughton-Jones exemplified in this respect the best traditions of his nationality. With regard to the paper itself, the subject thereof was of the greatest importance, and was one that was not often discussed. There was more insanity among women at the present time than formerly, and inasmuch as woman was the most civilising element in the community, it was a most important thing that they should study and practise all that was best in order to restore or maintain her health. Hence they were deeply indebted to Dr. Macnaughton-Jones for calling their attention to this subject.

Dr. W. J. SMYLY, Dublin, seconded the vote of thanks so eloquently proposed by Dr. Routh. The address to which they had listened was of the most deeply interesting nature, and was in itself an epitome of the opinions of the leading alienists and gynecologists on the subject. He wished also to echo the remarks of Dr. Routh on the brilliant Presidency which had come to an end that evening. He had himself been an original fellow of the Society, and could say that there had never been a time when the Society had passed through such a brilliant and successful phase as during the last two years. Eminent foreigners had been attracted to come and address them at their meetings; and the success had been largely due to the untiring activity of their President.

Mr. STANMORE BISHOP, in supporting the vote of thanks, remarked what a debt the Society, and especially the Provincial Fellows, owed to the President. There were many societies where a member felt that it did not matter to any one whether he was present or not; but

this was not the case with the British Gynæcological Society, every member felt at home, and this was largely due to the influence of the President.

The vote of thanks was carried by acclamation; and the President briefly acknowledged it.

The officers and council elected for 1900 are as follows:—

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France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, January 20th, 1900.

AMAUIROSIS.

M. DANLOS presented a man at the last meeting of the Dermatological Society who had contracted syphilis some three years previously, and from repeated attacks of iritis had almost completely lost his sight. He was submitted to different forms of mercurial treatment in several hospitals, and at one place received thirty injections of bin-iodide of mercury. That extended treatment but slightly improved his condition. When the patient entered the speaker's ward he was suffering from a severe attack of mercurial stomatitis, which had to be treated immediately. At the end of three weeks, the speaker was able to inject calomel subcutaneously, and the effect of the calomel was most surprising. The sight improved rapidly, and at the end of the fourth injection he had recovered completely. M. Danlos said that he had communicated this case for the purpose of re-habilitating calomel, which had been strongly attacked as a treatment of syphilis these last years.

M. Fournier said that calomel was doubtless a remedy for syphilis; certain lesions of the tongue or of the larynx, certain cases of phagedænum improved and even got well as by enchantment under the influence of that drug. But in other cases calomel has been known to

fail where injections of soluble salts of mercury, or even simple pills of proto-iodide gave very good results. Further, as long as a means was not found of sparing the patient the terrible pain caused by injections of calomel, the remedy should be reserved for exceptional cases. Another member observed that the dose of calomel varied with the individual; where grave accidents happened, the intolerance was perhaps due to glycosuria.

INFANTILE ECLAMPSIA.

Eclamptic attacks in infants being due for the most part to gastro-intestinal intoxication, the evacuation of the digestive tract is of first importance. However, this means did not always succeed in preventing recurrent attacks of convulsions, and in such cases bromides with or without chloral were generally prescribed. Dr. Lange has found that phosphorus frequently used for rickets exercised a sedative action on children, superior to the bromides. He administers it in the same, that is to say in a solution of oil, during three or four days to obtain a definite cure of the convulsions.

PULMONARY CONSUMPTION.

Dr. Mendel has instituted a new kind of treatment for consumption and which has given him considerable satisfaction. By means of a long curved syringe of the capacity of a drachm he injects through the mouth into the trachea about three drachms of the following solution:—

Essence of eucalyptus	} aa 3j ;
Essence of thyme	
Essence of cinnamon	
Iodoform, xx grs. ;	
Bromoform, x drops ;	
Sterilised olive oil, ʒiij ss.	

The tracheal injection is practised daily. The patient who feels the solution trickling into his lungs experiences an agreeable sensation of warmth and does not cough. In his early experiments Dr. Mendel operated with a mirror, but now he is able to dispense with that aid. The patient holds his tongue himself outside his mouth between thumb and finger by means of a napkin. The treatment is simple and inoffensive, and the effects varied with the stage of the disease. In patients in the first stage he has succeeded, after two or three weeks' treatment in relieving the cough and expectoration, and even stopping them altogether, strength, sleep, and appetite had also returned. In the two remaining stages of the malady the results were not so satisfactory, but still considerable benefit was obtained, expectoration easier and less abundant, strength and appetite improved.

In explaining the action of the treatment Dr. Mendel says that the medicated oil injected into the orifice of the trachea descends slowly, bathing the walls. It thus penetrates the bronchial tubes, creating a large surface of evaporation at the point where the bronchial tubes branch out. Before the oil is absorbed the air entering the lungs is saturated with volatile odours that destroy the bacteria.

In certain cases where the tracheal injections could not be performed daily, he has substituted a medicated enema composed of a glass of milk with the yolk of egg and from ten drops to two teaspoonsful of the solution mentioned above. Excellent results have been obtained from this treatment.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, January 20th, 1900.

GELATINE AS A HÆMOSTATIC.

The *Deutsch. Med. Wochens.*, 49/99, reports a case of almost fatal epistaxis cured by injection of a solution of gelatine. A woman, æt. 68, bled so profusely and continuously in spite of all ordinary measures, that half a litre of physiological solution had to be injected subcutaneously. The following treatment was then carried out, syringing of the nasal cavity with warm saline solution, to get rid of crusts and blood clot, then twenty to thirty grammes of warm fluid gelatine were introduced into the nose by means of a glass syringe with a wide nozzle, the *alæ nasi* being pressed upon the nozzle in order to prevent the gelatine at once running out again. After removal of the syringe, the gelatine hardened quickly, and the bleeding was arrested at once.

In the same journal a series of successful instances of the use of gelatine as a hæmostatic is given by Dr. Bauermeister. He used the gelatine internally in a 10 per cent. solution in three cases of hæmorrhage from the gastro-intestinal canal, and also externally in the form of a tampon soaked in gelatine, in several cases of epistaxis (in one of which plugging had been unsuccessful), in one case of profuse bleeding from the uterus, and always with prompt and good result. In only one case a case of hæmorrhage from the lungs, twenty to thirty grammes of gelatine daily failed to arrest it. The writer believes that it undoubtedly facilitates coagulation, and that when applied on the surface it can do no harm. As to its subcutaneous employment, he acknowledges that not enough is as yet known of its possible danger to encourage one to make a trial.

THE ORIGIN OF OXALIC ACID IN URINE.

The *Deutsch. Med. Zeitung* (103/99) gives a brief summary of an article on the subject by Dr. Felix Lommel.

The conclusions were mostly arrived at as a result of a series of experiments by the author on himself.

1. Oxalic acid found in human urine depends but little, if at all, on oxalic acid introduced into the system with the food.
2. By far the greater part is formed in the system itself.
3. The oxalic acid found in urine after taking large quantities of oxalates in the food bears only a very small proportion to that introduced.
4. The excretion of oxalic acid does not stand in direct relationship to decomposition of albumen.
5. Food rich in nuclein, as well as the known uric acid increase, also considerably increased the oxalic acid.
6. Food rich in gelatine also increased the excretion of oxalic acid.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, January 20th, 1900.

LUXATION OF CONGENITAL HIP DISLOCATION.

LORENZ is so convinced of the importance of his "bloodless operation" on the hip-joint for congenital dislocations, that he has taken the subject to the German

Surgical Congress for discussion. In cases of children born with the dislocation where the acetabulum becomes filled up, and the ligamentum teres absorbed after the course of years; in some cases, after the lapse of fifteen years, he has replaced the head of the femur over the accumulated deposit, and retained it in position till the pressure has produced a depression in the new growth and finally made a new acetabulum. He thinks the operation in unilateral luxation should not be undertaken by his method after ten years of age, while bilateral should not exceed the seventh or eighth year, and even with these ages great caution is necessary to prevent accidents incidental to the operation. The most severe of these accidents in his own practice was in the case of a girl, *æt.* 13, on whom he had operated, in whom gangrene of the leg ensued, from the head of the femur, getting entangled with the femoral artery in the reduction. He recorded ten cases where the head of the femur was fractured from the shaft, the patients' ages ranging from nine years to sixteen years, besides other fractures of the pubic and iliac bones. Twice he has had paralysis of the peronei muscles, and five times in the quadriceps. Out of 360 cases treated, he has had three die from chloroform, and twenty-two cases unaffected by the interference.

The patients above these ages he prefers Paci or Sen-ger's operations, as these affect the soft parts only, and offer a greater chance for a movable joint.

The frequency of the re-luxation forwards and upwards, has led Lorenz to take actinogrammes to show the relative height of the ligamentum teres, and the improbability of re-luxation backwards.

Petersen said that a form of reduction for congenital luxation had long been practised in Bonn, recommended by Schede, that could not be said to be a success as there was too much force applied. An apparatus had been devised to measure this force accurately, but with all this precision eight unilateral cases out of a total of 161 had been successful. In a very large number of the cases the head of the femur could not be retained over the site of the acetabulum when replaced owing to the absence of capsule and ligament while the cavity is filled up.

There are some cases with favourable conditions which admit of retention, and with slight inward rotation may be kept for a short time and finally retained, when an outward rotation may bring the bone again into its proper situation. During these periods of alteration a plaster of Paris binding is preferable.

Recently Schede has tried a forward twisting of the femur, and performed osteotomy under the trochanter. After three or four months' retention with a bandage in this inward rotated position the bandages are removed. The Röntgen rays are used while the head of the femur is turned to its normal position. While the child was under chloroform for osteotomy, a strong gold wire was passed through the trochanter into the neck of the femur with the ends protruding by which the upper part of the femur could be held in an inward rotated position after the plaster of Paris bandage was applied. After five weeks this wire or needle can be withdrawn, while the bandages may be removed three or four weeks later.

In the discussion that followed Mikulicz said that he had met with 100 such cases and found many of them easily replaced. He considered the luxation occurred in the

latter months of uterine life, probably many of them intra-partum. One of the principal hypothesis in the production of this displacement was the extraordinary development of the ligamentum teres which, by its interposition displaced the head of the femur. In many other cases we find an interposition of a capsule which seems to have grown in over the acetabulum, displacing the head of the femur outwards. He thought Lorenz's bloodless treatment the best method of managing these displacements, although some cases required more heroic operative measures. Heubner was in favour of Schede's treatment, combined with an extension apparatus. His experience led him to believe that 50 per cent. of such cases only required a corset or form of support for their correction, while 10 per cent. required operative treatment. He thought Lorenz's cases came under the former category.

The Operating Theatres.

CANCER HOSPITAL.

SUB-PERITONEAL HYSTERECTOMY.—MR. BOWREMAN JESSETT operated on a woman, *æt.* 30, who had been admitted suffering from large fibroids of the uterus. The tumour extended to about half an inch above the umbilicus, and laterally on the left filled up the iliac fossa of that side: *per vaginam* a large mass was discovered in Douglas's pouch pressing somewhat on the rectum, and causing some difficulty in defæcation. The uterine sound passed four and a half inches. The patient had extensive hæmorrhage, and her usual periods lasted from ten to twelve days; she was blanched from loss of blood. The whole tumour was fairly movable, and the woman suffered but little pain. Mr. Jessett made a long abdominal incision in the middle line, extending from the pubes and the umbilicus, and going about half an inch to the left side of the latter. The tumour with some difficulty was delivered and the broad ligaments ligatured on each side, clamps being applied on the uterine side to arrest any hæmorrhage; the bladder was found to extend very high up on the tumour; it was carefully peeled off and the anterior flap of peritoneum formed. Posteriorly the flap of peritoneum was dissected off and the uterine arteries were ligatured on each side. The cervix of the uterus was next cut through with scissors, leaving a wedge-shaped opening, and the tumour was removed. The wedge-shaped piece of the cervix was laced carefully together with catgut suture and the anterior and posterior peritoneal flaps were united with a very fine silk suture across the floor of the pelvis, care being taken to bury the stumps of the lateral ligaments which had been previously ligatured. The patient during the operation was in Trendelenburg's position. The parietes were closed by a single silkworm gut suture, care being taken to catch the different layers of integuments in the parietes with each suture. The patient bore the operation very well. Mr. Jessett remarked that it was often difficult to decide whether to recommend operation to women suffering from fibroids or not. He thought that in cases in which patients were losing large quantities of blood or in which pressure upon some important viscus or part caused great pain, or possibly pressure on the ureter produced hydro-nephrosis, operation should be recommended; in cases,

however, at or near the menopause, where the presence of the tumour caused no great trouble or inconvenience, then he considered the surgeon would not be justified in advising an operation, as doubtless a number of women go about with very little inconvenience, although burdened with fibroid tumours of moderate size, and, no doubt, after the menopause, the growths often decrease in size.

The subsequent progress of the case was most satisfactory.

PYLOROPLASTY AND CHOLECYSTOTOMY.—Mr. CHARLES RYALL operated on a woman, æt. 55, who had been admitted for constant sickness; she had suffered for a year from abdominal pain in the epigastrium and right hypochondrium which had never been paroxysmal in nature and never very severe. During the last six months she had suffered from sickness, which lately had increased in frequency and usually occurred after food; she had never had jaundice, and there was no history pointing to any previous attack of gastric ulcer. There had never been any blood in the vomit. The patient was greatly emaciated. On examination the stomach was found to be considerably distended, and there was tenderness in the right hypochondriac and epigastric regions, where an indefinite tumour, which was movable, could be distinguished. Malignant disease of the pylorus was diagnosed, and it was resolved to perform gastro-jejunostomy to relieve the sickness. On opening the abdomen by a median incision above the umbilicus, the pylorus was found to be the site of chronic fibroid thickening, causing stricture, and was not affected with malignant disease; the gall-bladder was found thickened and full of numerous calculi; it was therefore resolved first of all to perform pyloroplasty; this was done by dragging the pylorus out of the wound, shutting off the abdominal cavity with sponges, and making an incision in the long axis of the viscus, the wound was drawn apart and sewn up in the usual manner, the mucous edges being brought together by continuous suture, and the sero-muscular layers with a series of Halsted's sutures. The gall-bladder was next emptied through an incision below and parallel to the costal margin, and 256 calculi of various sizes were evacuated; the edges of the gall-bladder were stitched to the wound and drainage was resorted to. The median abdominal incision was then closed in three layers. Mr. Ryall drew attention to the condition of the pylorus, for it was often impossible, he said, to diagnose the condition he had found from malignant disease, as the pylorus may become so thickened as to form a definite tumour, the cause could not always be traced to an ulcer, but might possibly be, sometimes, the result of chronic dyspepsia. With regard to pyloroplasty the result, he said, was most satisfactory in cases of non-malignant stricture of the pylorus. The procedure was a very simple one, the object being to increase the calibre of the pylorus, this being done by making a longitudinal incision and converting it into a transverse one by drawing it apart in this position. He preferred this operation to gastro-jejunostomy, owing to its simplicity and lower mortality, and to Loreta's because after this latter the stricture so frequently recurs. As to the gall-bladder he pointed out that it was very strange the patient had never had an attack of biliary colic, as the thickening of the gall-bladder

and the surrounding adhesions pointed to a previous attack of cholecystitis. Although the pylorus was implicated in the adhesions; the gall-bladder, he pointed out, formed evidently the chief part of the tumour felt before operation. The gall-bladder was not closed, he remarked, after operation owing to the unhealthy condition of its walls, but was secured to the abdominal wound and drained.

The patient made an uninterrupted and very satisfactory recovery, all her symptoms being relieved, and the drainage wound gradually closing.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JANUARY 24, 1900.

UNQUALIFIED MEDICAL PRACTICE IN 1900.

IN spite of generations of active protest on the part of the medical profession the hydra-headed beast of unqualified practice rears its hundred heads with undiminished vigour. In the present year of grace, however, our readers are still awaiting, as their fathers and their grandfathers have done before them, the Hercules that shall demolish the evil monster that thrives upon the life blood of the nation. Everywhere quackery is rampant. No corner of the United Kingdom, no portion of our colonies, is too remote a field for the activities of the vendor of patent medicines and other nostrums, and of the unqualified quack who undertakes to cure fractures, dislocations, ruptures, cancer, cataract, rheumatism, baldness, deafness, consumption, epilepsy, and, indeed, every ill that human flesh is heir to. On the other hand, we have a legislature that is either indifferent or actually favourable to the continuance of piratical medical practice. At the present moment there are members of Parliament with large interests as directors and shareholders in some of the most extensive of the patent medicine companies that flood the country with their deceptive literature. It is a well-known

fact that during the life of a late notorious bonesetter, any attempt to introduce legislation against that branch of quackery would have been fruitless, owing to his wide *clientele* among members of Parliament and the aristocracy. The present state of affairs is ludicrous. Only when a bogus practitioner is incautious enough to give physic to his customers, does he lay himself open to prosecution by a clause that exists under the Apothecaries' Act. Why penalties should not be attached to unqualified practice except under that condition is a standing scandal to the consistency of British law. In this country it has been very rightly determined that the interests of the public demand that every man who practises medicine and surgery must first pass through a definite curriculum, and then be duly certified by a recognised medical corporate body as possessing adequate professional knowledge. Then the legislature and the General Medical Council proceed to keep a tight hand upon men qualified under stringent conditions. Outside practice, however, the thing that damages the public and stultifies the precautions of legitimate qualification is allowed to sap the vitality and plunder the purses of Her Majesty's lieges at its own sweet will. When will a British Government deal with this important question with the thoroughness it deserves? No real advance can be looked for until the General Medical Council, which has the ear of the Cabinet, is radically altered in tone, temper and constitution. The increase of number of direct representatives becomes in this way an essential of prime importance. So, too, the indirect increase of popular representation that would result by the electoral return of the council members of colleges and universities now nominated by some small governing body in each corporate constituency. As often pointed out, a great deal may be done by a better use of the weapons already in our hands. The General Medical Council has done one thing that places the profession in a much stronger position when asking for legislation against unqualified practice, namely, the abolition of the unqualified assistant. That small and unsatisfactory contribution appears to be all that can be expected from that quarter, and medical men must trust to themselves and their own organisation if they want any real and efficient protection of their professional interests. One way in which indirect good may be done lies undoubtedly in the direction of the reform of death registration. Many a prescribing and visiting chemist, and quack practitioner would be considerably restrained by the fear of a coroner's inquiry in all cases of improperly certified or uncertified death. On the part of the public there is a pronounced dislike to any difficulty about a death certificate, and that in itself would be certain to tell in favour of legitimate medical practice. The policy of the Registrar-General of Births and Deaths in the United Kingdom has lately shown a promising activity, so that local registrars now refuse certificates of death that they would formerly have accepted from unqualified persons. It is greatly to be regretted that there are

not more medical men in Parliament, where they might both initiate and inform the legislature upon medical matters. Some day it is to be hoped that our chief organisations, notably the British Medical Association, will see their way to pay members of Parliament out of the funds contributed by the profession. It is only when the necessary infusion of the professional element has been brought about that we may hope for satisfactory results. In many countries of Europe, such as Germany and France, quack medicines and quack medical practice are not tolerated, and it is no small reproach to the intelligence of the British Empire that she has not yet recognised the necessity of ridding her subjects of such noxious pests. That the day of retribution and enlightenment will come sooner or later cannot be doubted, and meanwhile the rank and file of the medical profession may be counselled to sink petty jealousies and to join every professional organisation that offers any hope of achieving some success, however trifling, in the long and arduous campaign against unqualified practice.

THE CO-RELATION BETWEEN SEXUAL FUNCTION, INSANITY AND CRIME.

THERE is perhaps no branch of medicine that has more points of contact with the law than gynaecology, and it may be added that there are few departments of medical jurisprudence where these points of contact are more enveloped in obscurity and uncertainty. The relation of insanity to disease of the pelvic organs; so-called criminal acts which may be the resultant of these two factors; questions of unchastity and venereal disease as they arise in the divorce courts; criminal assault; artificial abortion in all its aspects, including wounds in the uterus and evidences of past or present pregnancy; the duration of pregnancy; these are some of the questions on which important legal issues may hang; and upon which, unfortunately, knowledge is by no means precise. The co-relation of sexual function with insanity and crime was the theme chosen by Dr. Macnoughton-Jones for his Valedictory Address before the British Gynaecological Society. He first discusses the influence of the menstrual function on a woman's character; but here he rather raises questions than lays down doctrines. Alienists, of course, recognise the ætiological importance of puberty and of the menopause in relation to some forms of insanity; and between the establishment and the cessation of the function, the occurrence of menstruation may be associated with mental disturbances. It may, however, be stated categorically that menstruation is not a disturbing factor, except in women otherwise predisposed to derangements of the mind. In a healthy woman it may induce a certain degree of irritability and depression of spirits, but nothing more; it is in the mentally unsound that it may be associated with sudden maniacal outbursts or pronounced melancholia. The same line of thought may be adopted when discussing the relation of pelvic disease to insanity. It

is more than doubtful whether any pathological condition of the uterus or ovaries could lead to insanity, except as the immediately exciting cause in a woman already predisposed thereto. The numerous cases recorded in which the cure of pelvic troubles, by operation or otherwise, has been followed by mental improvement in no way invalidate this view; for they are most readily explained on the supposition that the restoration to a sound condition of mind was hindered by the pelvic disorder, as it would have been by disease elsewhere. It may, however, be granted that diseases of the sexual organs probably exert a more profound influence than disease in other parts of the body. We gather that Dr. Macnaughton-Jones had proposed to dwell on some of the other medico-legal points that we have enumerated, had time allowed; and we can only regret that time proved in this case an *edax rerum*, for we would gladly have heard some pronouncements on these topics from such a recognised authority. Meanwhile, more facts are badly wanted, and we should like to see instituted, under the ægis of some learned society, a commission composed of leading gynaecologists, expert pathologists, and recognised legal authorities, to investigate and report upon some of the medico-legal aspects of gynaecology. Such an investigation, thoroughly carried out, would prove of the greatest value both in medicine and in law, and would facilitate the solution of many questions affecting a large section of the community.

THE APPEAL OF THE GOVERNMENT FOR HOSPITAL ACCOMMODATION.

WHATEVER the shortcomings of the Government have been so far, we must commend them for the steps which they are taking to make ample provision for the treatment of the wounded soldiers during and after the war. It is well known that the hospital accommodation in South Africa is limited, and that there is no room for the treatment of soldiers whose wounds have clearly incapacitated them for further service. Hence the wise decision has been arrived at to draft all such soldiers back to this country as soon as they have recovered sufficiently to enable them to bear the passage. Perhaps in the interests of the wounded men it would be better to allow them to complete their convalescence in the Colony, having regard to the splendid climate which prevails there, in comparison with the exceedingly unfavourable climatic conditions to which they have to submit after landing on these shores. But however expedient it might otherwise be to keep the severely wounded men in South Africa, the plan is impossible for many reasons. The scheme of the Government at present is, after the usual Service hospitals are full, to take up beds for Service purposes at various hospitals which can undertake to provide them. Already, several hospitals in London have arranged to place a certain number of their beds at the disposal of the Government, some without requiring payment, and others in return for out-of-pocket expenses. It is understood that the beds so

allotted will be under military supervision, while all the necessary treatment and nursing will be provided by the hospital authorities. The progress of the war has already clearly demonstrated that a very large number of wounded men will find their way to this country, and will have to be provided for, and in thus being beforehand in their arrangements in this regard the Government are to be congratulated. Meanwhile, we regret to see that a serious charge has been brought against the management of the military hospital at Woolwich. A correspondent has asserted that all the experienced orderlies having been sent to South Africa the wards are practically in charge of inexperienced youths, who are quite incompetent to discharge the duties of attending to the large number of cases of typhoid fever which are now under treatment. The charge is further accentuated by the statement to the effect that the cases are "terribly neglected." We trust that if the state of affairs is really that which this correspondent describes, the Government will lose no time in making good the defect in management, or allow the sick men to be drafted at once into a civil hospital where every necessary medical and surgical provision will be made for them.

Notes on Current Topics.

Difficulties of Diagnosis.

THE difficulties of diagnosis which present themselves to the general practitioner are not always of a technical nature. It has often been stated that errors in medicine occur far more frequently from want of care than from want of knowledge, but there are, so-to-speak, mechanical difficulties in the way of careful examination which sadly hamper the practitioner, while they press but lightly upon the hospital physician. First of all, the average practitioner has to cram many more visits into his day's work than the consultant, and he has consequently less time at his disposal to devote to the individual case. Then there is the indisposition of the lower-class patient to submit to a really thorough exploration, particularly in affections of the pelvic viscera. The hospital physician finds his patient in bed, or can insist upon adequate removal of garments, so that there is no obstacle to his examination, but similar inquisitiveness on the part of the outside practitioner would be regarded as a needless indignity. The consultant has every facility for making analyses of excretions and secretions, &c., of searching for bacilli on the spot which the practitioner can only have done at great expense of time and trouble and even money. Lastly, the hospital physician is not hindered by the sight of parasites which, in the dwellings and on the persons of the poor, exert a very great disinclination on the part of the medical man to too prolonged and too close a contact with his patient. Theoretically, of course, none of these considerations should be allowed to weigh when the accuracy of the diagnosis is concerned, but in practice they constitute genuine, if not insurmountable, obstacles to careful work.

We urge these considerations not so much to excuse errors of omission as of the nature of mitigating circumstances which the consultant may well bear in mind when passing judgment on his handicapped and erring brother outside.

Recent Mortality Statistics of Hysterectomy.

It is but a few short years since that hysterectomy, except perhaps for cancer of the uterus, was considered by surgeons to be far too dangerous an operation for general application. Even now the text-books continue to propagate the view that uterine fibroids are things which will probably cease to trouble the sufferer after the menopause. We know that this bloodless termination is far from being the rule; indeed, the presence of a fibroid or fibroids will often indefinitely postpone the functional change. Nevertheless, in view of the risks which the operation entailed before its *technique* reached its present standard of perfection, the counsel to adopt a purely expectant treatment was usually followed. The modern abdominal surgeon, however, has changed all that. He has reduced the average mortality of the operation to something like two per cent., and in some hands to an even smaller proportion, so that it ranks as a less dangerous operation even than ovariectomy. These achievements are not confined to any particular method or procedure, for what one surgeon succeeds in doing through the abdomen another arrives at through the vagina. The latter procedure, however, is obviously unsuited for the removal of the uterus when associated with large growths. Under these circumstances surgeons are justified in claiming that many women who might with propriety have been regarded as unsuited for this particular operation some years ago may now with confidence be recommended to seek permanent relief by the removal of the source of their troubles.

Myopia and Military Service.

A CORRESPONDENT complains in a morning paper that he, while a good shot, rider, and in other ways fitted for service at the front has been rejected on account of his short sight. Yet he states that with glasses he can "see as far as any one, and can sight a rifle as truly as the best." All this may be quite true, but still his shortness of vision may be beyond that permitted by the army regulations. It may here be pointed out that the regulations lay down that a candidate must with each eye separately, without glasses, read at least $\frac{3}{32}$. If he can read $\frac{3}{32}$ with either eye he may be passed as fit if with correcting glasses he can read $\frac{1}{2}$ with one eye, and at least $\frac{1}{4}$ with the other eye, provided that at the same time he can read J 4. with one or both eyes, without glasses, at any distance he likes. Thus if any volunteer fails to come up to this standard, not we think a very exacting one, when it remembered that in the Navy a candidate must be emmetropic, it is evident that he has not much to complain of if he be rejected for

faulty vision. Moreover, in these days of long distance engagements with the enemy, there is no doubt that a premium will ultimately be placed on perfect powers of vision.

The Registered, but Unqualified Dentist.

THE practitioner of dentistry who obtained admission to the Dentists' Register by reason of his having been in practice before the passage of the Act is a thorn in the side of those who have at heart to raise the status of dentists as a class. Never having entered into an engagement to abandon his liberty of action in the matter of advertising, he is enabled to compete with his diplomated rival on highly advantageous conditions without let or hindrance. One by one these more or less irregular practitioners will drop out, and not until they have disappeared will dental practitioners attain professional rank, though even then it will be necessary to provide against the intangible limited company. In the meantime, we are pleased to see that the Royal College of Surgeons of England are taking steps to check the levity with which certain registered but unqualified dentists make use of titular letters which are calculated to mislead the public into the belief that they possess dental diplomas. Now that the attention of the General Medical Council has been called to the existence of this abuse we do not suppose much difficulty will be experienced in securing a declaration to the effect that it constitutes infamous conduct in a professional respect.

The State of New York and the Prevention of Tuberculosis.

THE State of New York has been considering the advisability of establishing State hospitals for the treatment of tuberculosis. The scheme proposed recommends that every locality able to provide a hospital for consumptives should do so, and that the State should erect and maintain one or more hospitals in districts which are unable to maintain local hospitals. As we have pointed out on previous occasions, the best way for dealing with this matter in this country would be by the organisation of municipal sanatoria. The trend of opinion is certainly towards making some such provision for those afflicted with consumption, and perhaps in the course of a few years that which at present is regarded as expedient will be looked upon as indispensable in this connection. We are still far from insisting, to the extent that continental nations do, upon the contagious nature of tuberculosis, but there is no doubt that in the interests of the public health it would be better were some system of isolation to be resorted to for the treatment of persons suffering from pulmonary phthisis. For example to have consumption hospitals in the midst of a crowded population, instead of in the open country, where the tubercle bacilli would have much less opportunity of doing harm, must be indisputably inexpedient. The more crowded the community into which the tubercle bacillus makes its way, the more virulent are its destructive effects likely to prove. Viewed then from

this aspect, it is quite likely that each of the hospitals into which phthisical patients are taken for treatment in, say, London, become a fertile focus of the disease, and are largely instrumental in its dissemination. If, however, provision were made, by means of municipal sanatoria, to treat all the phthisical poor in towns far away from the centres of population, we believe that a material reduction in the amount of dissemination of tuberculosis would be the result.

The War and the Sale of Drugs.

THE Government a short time ago issued a warning regarding the sale of gas products to foreigners, and since then a Royal proclamation has been gazetted prohibiting the exportation of picric acid, trinitro cresol, carbolic acid, and cresylic acid. The object of these orders is to prevent the enemies of the nation from obtaining supplies of products used in the manufacture of explosive compounds as lyddite. But it is curious to note, as pointed out by the *British and Colonial Druggist*, that in consequence of this action by our Government, a counter-prohibition has been issued on the Continent. That is to say, foreign makers have ceased to offer for sale in this country salicylate and salol preparations. "This," the trade journal in question observes, "might be looked upon merely as a natural result of the stoppage of crude material; but the articles that are being held back by Government instruction on the Continent are chiefly used for explosive material, and so the British Government may possibly find itself worse off by the move that it has made than if it had left the matter alone." The position of affairs in this regard is not without interest, but at the same time more or less disturbance of trade is already taking place owing to the inclusion of carbolic acid in the prohibition order. The effect of the order is to prevent, of course, the exportation of this drug for medicinal purposes, and thus Continental and other surgeons who rely upon carbolic acid as an antiseptic will apparently for the present have to resort to some other preparation for the purpose.

A Medical Strike.

It is not often that we hear of medical men striking *en masse*, but this extreme course was last week decided upon by the physicians attached to a charitable dispensary in one of the outlying districts of Paris. Unfortunately one is not in a position to discuss the merits of the case because the reasons alleged by the medical staff for their action do not in any way tally with those of the governing body. According to the former the reason is that they object to a recent ordonnance compelling them to confine their ministrations to children attending the municipal schools to the exclusion of those receiving their education in a denominational establishment. The governors on the other hand assert that the real reason is that the doctors disapprove of the appointment of a particular physician to be the head of the staff, the physicians, as a body, claiming

indeed, that their chief should be selected by themselves, a not unreasonable contention if seniority is not to be taken into account. However that may be, the usual appeal to outsiders to fill the vacancies has been made, and it is confidently asserted that no difficulty will be experienced in carrying on the work of the institution. The most regrettable feature of the quarrel is that the real victims are the unfortunate sufferers, who are thereby deprived for the time being of the care which they require.

The Royal College of Surgeons of England and Medical Aid Societies.

THE resolution passed at the last annual meeting of the Fellows and Members of the College condemning the connection of fellows and members with friendly societies and other institutions which advertise or canvass for patients has been endorsed by the Council of the College, so that in future one important section of the medical fraternity, at any rate, will be unable to complain that they lack guidance in this matter. Doubtless other licensing bodies will follow suit, and the hands of the General Medical Council will thereby be greatly strengthened in dealing with offenders. No unprejudiced person will hesitate for an instant to approve of the action of the College Council which will go far to reform a practice which had grown into a great abuse. It remains to be seen how the ordinance will work in practice. The resolution applies as well to registered friendly societies as to other medical aid institutions, and it is difficult to see how such societies can be carried on without a certain amount of canvassing. It may be supposed that the term canvassing will only be held to apply to the employment of professional canvassers, as distinguished from propaganda by individual members, in other words against collective, as distinct from individual, efforts to recruit. While we are strongly in favour of the movement, which has for object the suppression of this particular form of unfair professional competition some allowance must be made for the conditions under which these societies exist, and that proviso might well be that no profit should be made by the society or institution out of its medical department.

The Representation of the University of London.

WE welcome the announcement that Sir Michael Foster has consented to become a candidate for the vacant parliamentary seat for the University of London. If the expediency of this one-sided representation be conceded it is obvious that the selection ought to be made on intellectual, and not on political lines, indeed any derogation in this respect would infallibly open the door to hostile criticism of the system under which universities are allowed a special member all to themselves. The scientific status of Sir Michael Foster, tardily recognised by titular distinction, is such that in all probability no dissentient voice will be heard now that he has come forward so that a contest may become unnecessary. His eminence in the scientific

world needs no comment or illustration, and at this critical period it is in the highest degree desirable that the university should be represented by someone thoroughly imbued with the academical spirit, who is at the same time in touch with modern educational requirements. The views of Sir John Lubbock, the late member, by no means commanded universal assent, and although it is stated that Sir Michael Foster is substantially in agreement with those views, we know enough of him to be sure that he will decline to commit himself to any line of conduct which would hamper the future development of the new university now in progress of organisation. We wish Sir Michael every success in his electoral campaign.

The Profession and the Electric Light.

THE inhabitants of Cavendish Square, Harley Street, and the adjoining thoroughfares, which have become the great centre of medical life in the metropolis, have for years displayed a curious apathy in all that concerns local government. With little spare time at their disposal and vastly unwilling to compete with the baker and the tailor for places on the vestry they have had to put up with government by proxy, using such influence as they possess with their tradesmen to prevent their district becoming a veritable slough of despond. Now, however, the worm has turned in consequence of the utter *sans gêne* of the Metropolitan Electric Light Company which has displayed a proclivity to cut off the light, with or without notice, to the immense inconvenience of its customers. It cannot truthfully be said that the President of the Local Government Board, after listening to the recent deputation, held out much hope of effectual interference, indeed, the only remedy he seemed to have in view was competition. The next step ought to be a combined action in the law courts, for although the amount of damages any individual can recover is ridiculously small, the inconvenience to the company of such a method of warfare could not fail to be very great.

Total Abstinence from the Business Aspect.

A CONTRIBUTOR to the *Lancet* presents the temperance question in a very original form which, indeed, is a refreshing departure from the habit of the every day apostle of that cult. He addresses his argument specially to the medical profession, and it, for the sake of brevity, may be put in syllogistic form as follows:—1. Every working-class family in England on an average spends six shillings a week on liquor, and actually much more if deduction from the total of families is made for those who do not drink. 2. If they did not spend this money they would have more to give the doctor and would not be inclined to sponge on the hospital when sick. 3. *Ergo*, the doctor ought, in his own interest, to persuade all the working classes to be teetotallars. Q.E.D. We trust the doctor will do so, but not for this sordid reason, and we may add that as long as the hospital system is as lax as it is, the mean, selfish, working man would resort to the hospital even if his pockets were full of bank notes.

Lyddite.

LYDDITE, the new explosive is so called from the little village of Lydd, situated near Dungeness, in the south east corner of Kent, where it is manufactured. It is produced by the action of nitric acid on crystallised phenol, or to a mixture of phenol and sulphuric acid. On cooling a crystalline mass is obtained: Picric acid ($C_6H_3(NO_2)_3OH$): $C_6H_3O + 3HNO_3 = C_6H_3(NO_2)_3OH + 3H_2O$. Picric acid is easily soluble in hot but only slightly in cold water. It is also soluble in alcohol and ether. Its taste, as its name implies (*πικρός*), is intensely bitter, and its tinctorial power is very great. The explosive properties of the picrates were discovered accidentally. About two years ago a fire, occurring in a chemical factory near Manchester, burnt to ashes some carboys containing picric acid; the acid melted by the heat flowed on a quantity of litharge, thus causing a violent explosion. To form the explosive, melted picric acid is poured into the metal shell and allowed to cool. The detonating charge consists of a picrate of lead or ammonium. The explosive power is said to be fifty times greater than gunpowder.

The Anti-Vaccinationists and the War.

THE anti-vaccination party are waxing wroth with the authorities because volunteers, who present themselves for service in South Africa, are rejected if they cannot produce evidence of successful vaccination. The anti-vaccinationists pretend that they cannot understand what such an objection can have to do with fighting the rebel Boers. We need not undertake to enlighten them upon this point. Perhaps, however, it would be worth while in this connection to suggest to the anti-vaccination party that they should consult the records showing the number of French soldiers who died from small-pox during the Franco-Prussian war, in consequence of the neglect of vaccination.

Longevity in the Profession.

THE recent death of Sir James Paget at the age of eighty-five, recalls that many distinguished members of the profession have, at different periods, attained to a great age. Moreover, at the present moment two such physicians are still with us, one of whom is eighty-four, and the other eighty-three, while one surgeon is seventy-nine. All this goes to prove that robustness, and sound physical attributes have a great deal to do with success in life, perhaps, as much as that mental power, commonly described as "brains." In the great majority of instances, the most distinguished men of the world have been those whose mental and physical capacities have been equally great.

A Peculiar Assault.

IN the days of our youth it used to be thought a huge joke to watch the effects on the epidermis of the selected victim of the hairs of *miruna pruriens*, better known by the name cowhage, or cow-itch, as it is popularly called. The irritation to which it gives rise is "colossal," to use a German adjective,

and it may under certain circumstances determine a dermatitis of serious import. A young man hailing from the neighbourhood of Devonport resuscitated this form of practical joke on the person of a publican's wife, but he has since had reason to regret the fact, inasmuch as he has been mulcted in the sum of £10 *pour encourager les autres*.

Housing of the Poor.

A RECENT report upon the above subject by Dr. Priestley, Medical Officer of Health for Lambeth, has gone the round of the newspapers, and attracted a good deal of attention in official circles. His contention is that the Housing of the Working Classes Act would be better administered under Part II., which enables the authorities to deal with single houses, than by Part I., which deals with unhealthy areas. Broadly speaking, there is something to be said in favour of his view, inasmuch as the cost of proceedings under Part I. falls on the landlord, while under Part II. the burden is thrown upon the ratepayers. Beyond that Dr. Priestley's views appear to be fallacious. Part I. empowers an authority to abolish a whole area of undesirable dwellings, packed together under bad conditions of outside light and air, bordering on narrow streets, and placed perhaps back to back. Now although such an area might as a whole be most detrimental to the welfare of the surrounding district, yet it might be at the same time impossible on technical grounds to shut up any single one of its contributory dwellings. It is to be hoped, therefore, that those journals that have given publicity to Dr. Priestley's views will take prompt steps to publish the other side of the question. In many ways the housing of the poor, especially in our great centres of population, is one of the most urgent problems of the day. It would be a thousand pities to allow distorted readings of a beneficent although admittedly imperfect Act to be circulated as maxims of light and leading from an accredited source. There are already sufficient stumbling blocks in the way of those who are desirous of raising the general standard of environment of the working classes, without any further darkening of counsel from official quarters.

Sleeplessness.

THERE is no more distressing complaint than sleeplessness a nemesis that visits the coach of all alike from prince to peasant. That it comes to avenge some abuse of the brain appears to be abundantly clear. The labourer who lives in the open and works hard sleeps soundly as the proverbial top, unless he becomes the subject of some chronic bodily or mental disease that robs him of his slumbers. To a certain extent a similar observation holds good as to the artisan class in towns. The average citizen, however, who lives in the busy rush of latter day commercial or professional life, as a rule suffers from more or less pronounced insomnia, apart from disease of the kidneys, or other organs. In some cases the want of sleep may be readily traced to

abuse of alcohol, tobacco, tea or other nerve poisons. Want of exercise is a common factor that leads to want of sleep, for which a sensible doctor will be wise in prescribing golf, bicycles, or other exercises with early hours and plain living. Nowadays worry is beyond a doubt one of the chief causes of wakefulness, and anyone who can lessen the stress and storm of modern life will discover the best and safest soporific. Yet few of us would desert any express trains for the stage-coach of our grandfathers. What we want is to adjust our lives to the altered conditions of the twentieth century. No candid and scientific physician would use drugs in the treatment of sleeplessness, except to tide over an emergency. Change of air, change of scene, change of occupation, early hours, plenty of exercise, plain living, are some of the best remedies. Sometimes a Turkish bath and a low pillow will mend matters.

The Surgeoncy of the City of Dublin Hospital.

ON Friday last the Board of Governors of this hospital proceeded to select one from the three names recommended to them by the Medical Board for the surgeoncy of the hospital vacated by the death of the late Mr. Wheeler. As we have reported, these names were those of Mr. Harry Croly, M.B. and M.Ch. Univ. Dub., and formerly house surgeon to the hospital; Mr. Henry Moore, surgeon to Mercer's Hospital, and also an ex-house surgeon to the hospital; and Dr. Lane Joynt, assistant physician in the Meath Hospital. When the governors met a letter was read from Mr. Harry Croly withdrawing his candidature on the ground that he did not desire to contest the position with Mr. Moore, and thereupon Mr. Moore was unanimously chosen to succeed Mr. Wheeler. We understand that Mr. Harry Croly has since offered himself for the surgeoncy of Mercer's Hospital vacated by the transference of Mr. Moore, and his valuable experience as house surgeon to a very active hospital ought to give him a recognisable claim.

Civil Surgeons at the Front.

THE medical profession has not only shared the deep wave of emotion that is sweeping over the British nation, but has been able also to contribute its quota of active help. The latest additions to the list have been made in the persons of Mr. William Turner, F.R.C.S., Assistant Surgeon to the Westminster Hospital, and Mr. Reginald Johnson, F.R.C.S., of University College Hospital. It is understood that Mr. Turner will be appointed to the Base Hospital of the Imperial Yeomanry, and will sail on the 27th. In addition to the foregoing, the London hospitals are at present represented in South Africa by the following distinguished surgeons. St. Thomas' by Sir William McCormac and Mr. Makins; the London by Mr. Treves; King's College by Mr. Watson Cheyne and Mr. Cheadle; Guy's by Mr. Fripp; St. Bartholomew's by Mr. Anthony Bowlby and Mr. Tooth. For the present nothing more need be said than that the

heartly sympathy and confidence of the profession are freely extended to this gallant little band of men chosen from the flower of Metropolitan surgery to succour the brave soldiers who are fighting our battles in South Africa.

Revision Classes at Westminster Hospital.

SPECIAL "revision" classes for the furbishing up of candidates for university and similar examinations are now held three times a week in connection with the Westminster Medical School. The plan adopted is to take a selected subject in pathology, which is duly discussed, and the points raised are subsequently illustrated by practical microscopical work. The course commences on the 30th inst. Time was when students belonging to one or other of the smaller medical schools were compelled to turn from their *alma mater* so soon as they aimed at anything above a mere qualification to practice. That time, however, is no more, and there are signs on the contrary that the smaller schools, with their proportionally larger proportion of clinical material are attracting the senior men from the more crowded centres of medical teaching to their special classes.

The Combatant "Non-Combatant."

THE *Cape Times* of the 14th of December, pays a high compliment to the conspicuous gallantry of Mr. Delap, a Surgeon attached to the G battery of Artillery, now with Lord Methuen. He was in the action in which the Marquis of Winchester was killed, and was noted for his courageous determination when attending the wounded on that occasion. Mr. Delap is a Licentiate of the Dublin Colleges, and son of the Rector of Valentia, co. Kerry.

PERSONAL.

MR. EDGAR A. BROWNE, F.R.C.S.Edin., has been elected President of the Liverpool Medical Institution.

THE Marquis of Zetland has given his house, Herse House, Falkirk, for the sick and wounded from South Africa.

MR. ALFRED COOPER, F.R.C.S., will open the discussion on syphilis at the meeting of the West London Medico-Chirurgical Society next month.

MISS JANE GILMOUR COX has been appointed junior assistant Medical Officer of the Lincolnshire Lunatic Asylum.

MR. WILLIAM ANDERSON, F.R.C.S., has been elected a member of the Board of Examiners of the Royal College of Surgeons of England.

MR. C. N. MACNAMARA, F.R.C.S., has been selected to deliver the Hunterian Oration at the Royal College of Surgeons in 1901.

SIR JOHN WILLIAMS, M.D., F.R.C.P.Lond., has been placed on the Commission of the Peace for his native county, Carmarthen.

MR. ARTHUR CHANCE, F.R.C.S.I., has been elected a member of council of the Royal College of Surgeons, Ireland.

DR. H. FRANKLIN PARSONS has been appointed Assistant Medical Officer Local Government Board and Medical Inspector for General Sanitary Purposes. Dr. R. Bruce Low has also been made an Assistant Medical Officer.

MR. ALFRED FRIPP, F.R.C.S., Surgeon-in-Ordinary to H.R.H. the Prince of Wales, assistant surgeon to Guy's Hospital, is named for the post of surgeon in charge of the proposed Yeomanry hospital.

MR. WM. HY. POWER, whom we mentioned a month ago as the likely successor of Sir R. Thorne-Thorne in the Principal Medical Officership to the Local Government Board, has now been appointed to that important post.

MR. J. N. C. DAVIES-COLLEY, having resigned the post of examiner in surgery at the Royal College of Surgeons, England, the Council will proceed to the election of his successor on February 8th. Notice to Fellows will be found in another column.

THE vacancy in the Committee of Management which conducts the conjoint examinations for the Dublin Colleges, created by the departure of Sir William Stokes for Africa, has been filled by the Council of the College of Surgeons by appointing Mr. F. R. Heuston, surgeon to the Adelaide Hospital.

DR. GEORGE BURBIDGE WHITE, F.R.C.S.I., sometime pathologist to the Meath Hospital and demonstrator in the Royal College of Surgeons of Ireland, announces his candidature for the surgeoncy of the Mercer's Hospital, Dublin, vacated by the transference of Mr. Henry Moore to the surgeoncy of the City of Dublin Hospital.

THE field hospital provided by the munificence of Lord Ivegh will leave Southampton early in the second week in February, its departure having been somewhat delayed for want of transport. Sir William Thomson, who is in chief medical charge, will leave by the ordinary mail steamer on February 3rd so as to have final arrangements made for the arrival of the expedition which will leave by transport a few days afterwards. We have already given the details of the organisation and the names of the medical officers in charge.

WE understand that the Royal College of Physicians of Ireland has called the attention of the Council of the College of Surgeons to the fact that it has felt itself called upon to require Mr. James Charles MacWalter, of Dublin, one of its Licentiates, to surrender his diploma for having resorted to methods of obtaining practice which that College regards as inconsistent with his pledge given when it was granted to him. Mr. MacWalter is known to be actively employed in managing one or more of the seven druggists' shops which

trade in Dublin under the title of Leonard and Co., and he was also the promoter of the abortive Company which started under the title of "Blaud and Co.," to carry on the business of physician, surgeon, and midwifery practitioner, as a limited company. On reference to the *Medical Register* we find that this gentleman held, until his resignation of the physician's Diploma, three qualifications, viz., the Diplomas of that College, and of the College of Surgeons, and also the Licence of the Apothecaries' Hall. Having now ceased to hold the first-named qualification, he retains two, and, therefore, remains on the *Register*, but if he should lose another Diploma, the question will remain as to whether the General Medical Council can leave his name on the official record in respect of one Diploma. We understand that the Council of the College of Surgeons has remitted to a committee to investigate and advise upon the matter.

THE DUBLIN HOLOCAUST.

THE Lord Lieutenant has ordered a departmental inquiry into the causes of the excessive death rate of the City of Dublin. The Commission is to consist of a representative of each of the following bodies, viz., The Irish Local Government Board (probably the Medical Commissioner, Dr. Stafford); the English Local Government Board (possibly Mr. T. W. Russell, M.P.), the Corporation of the City (representative not yet selected); the Royal College of Physicians (Dr. J. W. Moore, President); the Royal College of Surgeons (Dr. R. L. Swan, President); Sir Charles Cameron, Superintendent Medical Officer of Health for the City will, of course, be active in assisting the deliberations of the Commission. Meanwhile the health condition of the City is by no means improving. The Registrar General reports, on the 13th inst., a death-rate of 49.4 per 1,000 of the population, with a considerable increase in the zymotic mortality.

MEDICAL SOCIETY OF LONDON.

At the meeting of this society, which took place on Monday evening last, Mr. C. B. Lockwood read a paper on "The Pathology and Treatment of Appendicitis," which was illustrated by numerous lantern photographs of the appearances described by him. He discussed the alleged cure which was stated to have taken place in these cases under medical treatment observing that subsidence did not imply cure. By the aid of photographs of sections the author showed that the infection spread to the peritoneum through the lymphatics, the spread being favoured by the anatomical arrangement of the tissues. He described the different varieties of the disease ranging from mere appendicular colic to catarrh, stenosis, and finally gangrene and ulceration, remarking that the conditions appeared to be opposed to any natural process of cure.

Dr. Allchin contrasted the trend of current opinion in favour of the surgical treatment of appendicitis with the days when one's knowledge of this particular affection might be described as exceedingly vague and largely incorrect, and the treatment as an attitude of unregulated expectancy. While admitting that much had been learned concerning the pathology and treatment of the disease, he declined to admit that an operation must be regarded as indispensable unless and until pus had been shown to be actually present. He described four groups of cases: (1) the sudden, fulminant cases, rapidly proceeding to a fatal issue; (2) the less acute, but still acute, cases in which, after some days, an abscess formed; (3) the ordinary run of cases, as seen in the medical wards in which, after a fortnight or so, the symptoms subsided, and the patient was apparently cured; and (4) the relapsing cases. It was in the third group that he

thought the physician had still a useful sphere of action, and incidentally he remarked on the value of small doses of opium. In view of prognosis, he attached most importance to an increase in the rapidity of the pulse. Each case must be judged on its merits, and he deprecated any dogmatic rules to the effect that the patient must be allowed to pass so many days or must have had so many relapses before the question of operation was decided.

Mr. A. Barker thought the infection of the lymphatics, which the author had demonstrated, afforded a sufficient explanation of several very difficult classes of cases, notably those in which there were outbreaks of inflammation at a distance, including subphrenic abscess. He concurred in the view that opium was beneficial, and insisted on the bactericidal powers of the peritoneum, and he said that even in widespread suppuration he was careful to limit his intervention to the smallest possible area of peritoneum.

Dr. F. Smith commented on the fact that in the majority of cases of ulcerated appendix there was no previous history of pain, a point which was also observed in many cases of gastric ulceration. He remarked that even in the post mortem room it was practically impossible to cleanse the peritoneum, and he doubted whether any surgeon could effect it on the operating table. Observations on a large number of autopsies had led him to the conclusion that the most common position for the appendix was behind the cæcum or ascending colon. Surgeons should therefore make their incisions in a spot which would allow of their reaching that region.

The further discussion was adjourned to February 24th.

Obituary.

DR. WILLIAM A. HAMMOND.

THE death is announced of Dr. William A. Hammond, Surgeon-General of the United States Army during the Civil War, long a prominent figure in American medical circles. He graduated at Newport in 1848, and in 1849, when he became of age, he entered the army as assistant surgeon. In 1862, he became Surgeon-General of the army, with the rank of Brigadier-General. He instituted many changes, all in the direction of more efficient organisation, established the Medical Museum in Washington, and, most important of all, suggested and carried out the plans from which resulted publication of the "Medical and Surgical History of the Rebellion." After an unpleasant incident in connection with his administrative conduct he was dismissed from the army in August, 1864, whereupon he resumed the practice of his profession in New York, devoting his attention to nervous diseases, in which he soon acquired a recognised position. He was also professor of mental and nervous diseases in the Bellevue Medical College, retiring from this post in 1882 to become one of the founders of a Post-Graduate Medical School, removing, some years later, to Washington where he afterwards resided. In 1879 he was restored to his place in the army as Surgeon-General, and retired with his old rank of Brigadier-General.

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

BACON RASH.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In reply to the query contained in your last issue, perhaps I may be allowed to remark that instances of this form of "alimentary idiosyncrasy" are by no means rare, though I cannot remember bacon in particular having been mentioned as the source of the trouble. Pig flesh, however, is known to cause cutaneous eruption of the urticarial type in a comparatively large

number of persons; while cheese, eggs, certain vegetables and fruits are often incriminated.

It simply amounts to the fact that certain people are unable to digest particular articles of food, and failing proper digestion we get intestinal fermentation with its cortege of symptoms.

In some cases I have been able to convince myself that the disability is purely imaginary, the idea dating from a digestive disturbance of fortuitous occurrence. When the attention of the alleged victim of the idiosyncrasy has been diverted from the dish no ill-effects have followed. I have seen the same thing happen to Englishmen who have been beguiled into eating frogs' legs. Until they were apprised of the nature of the diet all went well, but no sooner did they learn its nature than they experienced nausea and even vomiting. A sudden emotion, such as intense disgust, may, even if retrospective, temporarily arrest or hinder digestion, whence the evolutions of the familiar symptoms.

I am, Sir, yours truly,

CREDÉ.

Literature.

ALLBUTT'S SYSTEM OF MEDICINE. (a)

THIS monumental work has at last been brought to a successful conclusion, at least we presume so from the fact that the present volume contains a general index that it is the last. It is comprised in eight volumes, the first of which was published in 1896. It contains about 7,770 pages, exclusive of the indexes and not counting the 'System of Gynecology.' It has involved the expenditure of about 4,000,000 words. Each volume is published at 25s. net., so that the total cost of the set, including the gynecology, is £11 5s. Among the contributors are to be numbered some of the most brilliant medical writers of the day. It has been the medium of publication of much good original work, some of which will have an enduring influence on the progress of medical science. To whom should be assigned the credit of having contributed the best article it would be difficult to say, and we have no desire to undertake so onerous a duty. That some of the articles have been lamentably feeble is generally acknowledged; but here again it would serve no useful purpose to indicate them by name. The good articles will be read and carefully studied, whilst the poor and indifferent ones will be ignored. Comparing the volumes we are inclined to assign the palm to Vol. VII., although all the articles on diseases of the nervous system are of a very high order of merit. Vol. I. was somewhat unsatisfactory, and the inclusion of an article on Nursing by a lady connected with a Union Workhouse, excited unfavourable criticism. That many of the articles, not only in that but in the succeeding volumes, would have been better for judicious pruning is obvious.

The volume before us contains the remainder of the "Diseases of the Nervous System," commenced in the sixth volume, "Mental Diseases," and "Diseases of the Skin." Most of the articles are short, a fact which may be gathered from the circumstance that no less than 42 authors have been concerned in the production of this volume. The first article, on "Craft Palsies," is by Dr. Vivian Poore, whose name one naturally associates with this subject. It is written in his characteristically vivid style, and deals with such diseases as writer's cramp, telegraphist's cramp, and sawyer's cramp. He calls especial attention to hephestic palsy, which occurs in those who wield light hammers for forging such articles as nails and the blades of pen knives. He also includes in this category miner's nystagmus, which is clearly a craft palsy analogous to writer's cramp and similar troubles. Next comes an article on "Spasmodic Wry Neck" or Torticollis, by John Chiene of Edinburgh, a contribution which, although short, is thorough, and contains details

of cases in which neurectomy was performed. Prof. Chiene, in a note or postscript, mentions that his article was written in 1896.

"Facial Spasm" and "Tetany" fall to the lot of Dr. Risien Russell; while Sir William Gowers deals with the somewhat difficult subject of "Paralysis Agitans." We are glad to see that the name shaking palsy is retained, and that the attempt to call it Parkinson's disease meets with but little favour. It must be admitted that our knowledge of the treatment of this distressing malady is very limited, and that the medicinal remedies commonly employed avail but little.

"Migraine" or Megrim has been entrusted to Dr. James Mackenzie of Burnley. We think that it is somewhat disappointing, and that it contrasts unfavourably, especially in the matter of treatment, with Edward Liveing's classical "Contribution to the Pathology of Nerve Storms." Dr. Omerod of whose article in conjunction with Dr. Mott, on "Tabes Dorsalis" in Vol. VII. we spoke in terms of the highest praise, deals with the subject of "Hysteria," and again acquits himself well. He is very cautious in his expression of opinion with respect to the value of the Weir-Mitchell treatment. He enumerates so many conditions in which he considers that the results are "less favourable" that it is not very difficult to read between the lines. Dr. Patrick Manson contributes a weird article on "Latah." It is original, and is well worth reading. It is very short, and it would be a pity to spoil it by making an abstract of it. It is very entertaining, and might be published separately as a Christmas number of the "System of Medicine." The other articles on nervous diseases are of the conventional type and call for no detailed criticism.

The articles on "Mental Diseases" are for the most part by Dr. Savage, Dr. Rayner, Dr. Clouston, Dr. Mercier, and Dr. Fletcher Beach. Dr. David Nicholson, C.B., deals with "Criminal Lunacy in England," and his article is pointed with good stories of his old Broadmoor days. The fact of his being now a Lord Chancellor's Visitor in Lunacy does not appear to have spoilt his ability to tell a good anecdote with plenty of "go" in it. We are glad to find an article by Dr. Outtersen Wood dealing with "English Law and Practice of Lunacy," for there are few men in his special department for whose opinion we have greater respect. His views on the treatment of nervous diseases by hypnotism would be worth reading.

The Skin Department is under the control of several well-known dermatologists, including Dr. Payne, Dr. Galloway, Dr. Stephen Mackenzie, Dr. Radcliffe Crocker, Dr. Colcott Fox, and Mr. Malcom Morris. The selection must have been an extremely difficult one, especially as competition in this department is keen. Dr. Fox leads off with "Erythema," "Lichen Urticatus," "Prurigo," and "Urticaria." His articles are thorough, but he errs on the side of over-conscientiousness especially in the matter of quoting authorities when his own assertion would answer the purpose. Dr. Payne contributes a good, clear, solid article on "Eczema," which is as free as any article on skin disease can be from the endless refinements of the specialist. Mr. Malcolm Morris deals ably with "Parasitic Diseases of the Skin," and manages to get a good deal of useful information in a very small compass. His article is practical, and he does not trouble much about other people, but tells his story in terse, vigorous language. There are many articles in this volume which, although doubtless of very great interest to the pure dermatologist will, in all probability, be rarely referred to by the general physician. As examples, we may mention "Rhinoscleroma," "Ainhum," "Craw-craw," "Xanthoma," "Mycosis fungoides," and "Darier's Disease."

GADD'S SYNOPSIS OF THE BRITISH PHARMACOPOEIA. (a)

THIS is a most useful little book and one which

(a) "A System of Medicine. By Many Writers." Edited by T. Clifford Allbutt, M.D., F.R.S. Vol. VIII. London: Macmillan & Co., Limited. 1899.

(a) "A Synopsis of the British Pharmacopoeia, 1900." By H. Wippell Gadd, with analytical notes and suggested standards by C. G. Moor, M.A.F.I.C., Public Analyst for the City of Exeter. 4th Edition. London: Balliere Tindall and Cox, 1900. Price 1s.

cannot fail to prove of value both to students preparing for examination and men engaged in active practice. It contains a complete table of all the chemicals, drugs and preparations in the *British Pharmacopœia* of 1898 with their characters, doses and other particulars. It is all so conveniently arranged that the *Pharmacopœia* itself is superfluous. It can be carried in the vest pocket and is available for reference at a moment's notice. The analytical notes are excellent and will be of great use to public analysts.

AITCHISON'S MEDICAL HANDBOOK. (a)

THIS is the third edition of an excellent little handbook for the use of practitioners and students. Within the brief compass of some three hundred and fifty pages an immense amount of material is condensed, yet the production is in no sense of the word a cram-book. Many busy practitioners require from time to time to refresh their minds by a systematic review of medicine brought concisely in line with modern progress. For such a requirement it would be difficult to imagine a work more fitted than the present, which is a marvel of condensation. The complex and wide subject of nervous diseases is well treated. Wisely, as we think, the author has contented himself with a classification of skin diseases, and has thus avoided the perfunctory section upon that complex branch of medical study which the writers of kindred books sometimes present to their readers. The book requires somewhat close reading, but the more one dips into its pages the more it becomes evident that no detail of importance is omitted. In dealing with so wide a subject a result of that kind connotes most careful and skilled authorship. The publishers may be congratulated upon the high standard of this volume.

NORMAN WALKER ON SKIN DISEASES. (b)

OF recent years British writers have not distinguished themselves by any great discoveries in dermatology. It is therefore a real pleasure to meet a writer who not only displays originality but who also has the courage of his opinions. Such an author is Dr. Walker, whose views in some instances differ widely from those of orthodox dermatology. He constantly quotes Unna, an indefatigable worker in the histology of the skin and an acknowledged authority in many branches of dermatology.

Dr. Walker apparently refuses to worship at more than one shrine. Take, for instance, seborrhœa, in which Unna's views as to the micro-coccus are adopted, but no mention is made of Sabouraud's observations and experiments upon a small bacillus found in seborrhœic hairs. Dr. Walker regards psoriasis as a form of seborrhœic dermatitis, a view which, however startling, is already held by some few dermatologists. He does not mention the fact, however, that the original observation that at once cut off a great class of scaly eruptions from the entity known as "psoriasis" was published some years since at the Newcastle meeting of the British Medical Association. While in the critical vein we must protest against the mistaken jocularity that here and there mars these pages. Thus in speaking of scabies he writes, "the removal of the clothes . . . seems to be to the acari an intimation that the time for their nightly prowling has arrived." Again: "Mr. Hutchinson says that arsenic is our *sheet-anchor* in treatment (i.e., of pemphigus). It is fortunate that our mercantile marine have more reliable anchors than that furnished by arsenic in this disease." In dealing with the etiology of urticaria Dr. Walker refers to a large number of blood-borne irritants as "internal irritants," a term that was received with derision some ten years ago but is now becoming adopted by various writers upon dermatology. He does not regard these internal irritants as reflex in their action, but shelves the difficulty of any precise

theory or conclusion by saying they are probably "poisons" brought by the blood stream to the skin. How do they then act? Curiously enough, acute and chronic urticaria appear to have escaped formal description. For the general arrangement of the book, for its clearness, its thoroughness, its practical bent, its freedom from mere academic trammels we have nothing but praise. We have no hesitation in saying that in future editions we look forward to being furnished with a handbook of which the Scotch school may be proud. At the same time, the literary style demands careful revision. The numerous illustrations, coloured and otherwise, are of high artistic merit.

SMITH'S DIFFERENTIAL DIAGNOSIS. (a)

THIS is an excellent book, which gives in terse form much information that the physician has hitherto had to think out for himself. It may be best described, perhaps, as a critical analysis of clinical symptoms founded on a wide bedside experience, and based on a sound knowledge of physiology and pathology. The essential significance of signs and symptoms is the key to the author's method, and they are discussed both as standing alone and in their relation to groups of local diseases. The section on diseases of the urinary organs is particularly clear and full, and will act as a sketch map to any medical man who is investigating an obscure case of renal origin. An extremely practical point is the differential diagnosis of alcoholic coma; nowhere else in medical literature do we recall any account of so full and careful a nature. Assuredly every medical resident in hospital, to say nothing of police surgeons and general practitioners, should lay these maxims to heart. If more stress were laid upon such necessary knowledge in the course of medical education there would be less heard of the constantly-recurring scandal which is announced in the newspapers under the heading "Drunk or Dying." The index of this excellent volume bears signs of haste. We do not find, for instance, any mention of enteric fever. Widal's test for that disease—spelt in the text, by the way, as "Weidal"—is omitted from the list, nor is it mentioned under typhoid or enteric fever. Dyspepsia *v.* heart pain is given as p. 32, when it should be sixty-two. However, these are not very serious flaws. A somewhat striking omission in the body of the book is that of dropsy. Surely a differential diagnosis of the varieties of so common a sign would be of importance to medical men who are every day being called upon to investigate its bearing upon diagnosis and prognosis. Any little imperfections, however, of this kind will doubtless be cleared up in future editions. We welcome this contribution to current medical literature. The number of useless and unnecessary medical books is legion, but here we have a new departure that is shown by a glance to have more than justified its existence. Dr. Smith may therefore be assured that his book falls within the category of the useful and the desirable.

PYE'S SURGICAL HANDICRAFT. (a)

THE fourth edition of this useful little manual, owing to the death of the original author, has been revised and edited by Dr. Bertram Rogers. The fact that another edition is called for is in itself sufficient testimony as to the need of such a work, the aim of which has always been essentially practical, a point that has been steadily maintained in sight of the present issue. In the section dealing with catheters the importance of cleanliness is properly insisted upon, although we think the passage fails in emphasis where it says, "it is a question whether the duty of cleansing catheters after use should ever be left to nurses or porters." So far as that goes we fancy no careful surgeon would trust the cleansing of his catheters to anyone other than himself. Some trust-

(a) "A Medical Handbook." By R. S. Aitchison, M.D., F.R.C.P.E., late Medical Officer, Out-patient Department, Edinburgh Infirmary. Third Edition. Numerous Illustrations. London: Chas. Griffin and Co. 1899.

(b) "Introduction to Dermatology." By Norman Walker, M.D., F.R.C.P.Ed., Asst. Phys. Diseases of Skin, Edinburgh Royal Infirmary. Bristol: John Wright and Co.

(a) "Differential Diagnosis with Clinical Memoranda." By F. J. Smith, M.A., M.D.Oxon., Physician and Senior Pathologist to the London Hospital. London and New York: Macmillan and Co. 1900. Price 7s. 6d.

(b) "Pye's Surgical Handicraft." Edited by Bertram Rogers, M.D.Oxon. Fourth edition. Illustrated Bristol: Wright and Co. 1900.

worthy means of cleansing soft catheters is still urgently needed. Then, when we come to hypodermic injections the need of sterilising syringe, fluids, and so on is not mentioned at all, while the important point of antitoxin administration is dismissed in a few words. The articles on aural and dental surgery have been revised. On the whole, Dr. Rogers may be congratulated upon the way in which he has performed his task, and preserved the spirit of Mr. Pye's original work while adding to its detail and bringing its subject-matter up to date. As everyone knows, a great many of the things dealt with in these pages, although essential to everyday practice both inside and outside hospital, are not described elsewhere. We have no doubt that among practitioners, especially hospital residents and students, this book will not only retain but add to its old reputation.

ASHBY & WRIGHT'S DISEASES OF CHILDREN. (a)

THE first as well as the latest edition of Ashby and Wright's work lies before us. The former is dated 1889. In ten years four editions have appeared. The first consisted of 681 pages with 138 figures; the last has grown to 872 pages with 217 illustrations and fourteen plates.

This product of the Manchester School of Pediatrics has from the first received a well-merited welcome. It is probably the most concise and complete work on diseases of children in English judged from the standpoint of the practitioner and senior student. It is especially practical. The basis of the authors' work is their experience at the Manchester General Hospital for Sick Children. The collaboration of physician and surgeon has ensured a complete and comprehensive presentation of the ailments of childhood.

In the present edition the whole work has been thoroughly revised, and many of the chapters have been entirely rewritten. Considerable additions have been made to the text, and, as already indicated, some sixty pages, twenty-five new photographs and fourteen plates have been added. Mr. Alexander Wilson has also re-written his valuable section on anæsthetics.

This work is so well known, and so highly prized that any special recommendation of the new edition is unnecessary. Nevertheless, it is pleasing to note that the additions, and revisions are such as will greatly enhance the value of the book for practical purposes.

Separate chapters are now devoted to infantile scurvy, rickets, and tuberculosis. The section on the diseases of the blood and blood making organs has been considerably extended. The introductory remarks on affections of the nervous system will prove of particular service. The pages devoted to mental affections in childhood will be of deep interest to the many now devoting their time and attention to the care and training of backward and defective children. In connection with the consideration of renal new growths now recognised as of such importance in children, the authors make due reference to the recent researches of Dr. Kelynack, another member of the Manchester School. The sections on bones and joints, as would be expected from the pen of such an experienced surgeon as Mr. Wright, are admirable. The new skiagram illustrating "travelling acetabulum" in hip disease is of much interest. Other skiagrams illustrate club-hand, congenital dislocation of hip and separation of epiphyses.

The Appendix contains useful notes on modified milk, milk sterilisers, antipyretic methods, narcotics, purgatives, ferments, gavage, enemata, the physiological alphabet, and many other points likely to be of particular service to young practitioners.

No junior medical practitioner can consider his armamentarium complete without this book. In size, substance, and manner of presentation it stands out as the ideal work for the busy general practitioner. The present edition will do much to more firmly establish this joint production as our best English handbook on the diseases of childhood.

(a) "The Diseases of Children. Medical and Surgical." By Henry Ashby, M.D., F.R.C.P., and G. A. Wright, B.A., M.B., F.R.C.S. Fourth Edition. Thoroughly revised. London: Longmans, Green and Co. 1899. 25s.

HEALTH ABROAD. (a)

THIS timely work is evidence of the growing interest which Englishmen are taking in men and things outside their "island home." Insular prejudices are being swept away by the spirit of Imperialism and a deep and scientific interest is now taken in all matters which influence the health of those who travel or reside in countries the climate of which may in any way prove pathogenic. The enthusiasm for researches on tropical diseases, awakened study of medical climatology, and numerous recent publications on the relations of travel to health, all indicate an eagerness for the conquest of disease as well as it may be for the acquisition of territory.

The main object of the present work is to enable the ordinary traveller to preserve his health whilst travelling in unknown climates, to be familiar with the various emergencies which may arise when medical aid is not forthcoming, and to treat them to the best advantage.

The articles have been written by those who have had personal experience of the district or country they describe.

The editor is rightly careful to impress his readers with the fact that the "work is not intended to obviate the necessity of seeking medical aid." He points out very truly that "matters which at home are of small moment are, in a new climate, and under unaccustomed conditions of travel, often apt to be either serious in themselves from the beginning, or to become serious if left untreated or treated improperly, so that no time should be lost in seeking skilled advice."

Two difficulties are experienced in producing such a work as this. First that there is a great similarity between the conditions which are unfavourable to health in various parts of the world, and between the diseases which are in fact chiefly prevalent, and secondly that there are numerous local diseases, or varieties of diseases, which cannot be dealt with in detail.

The editor and his contributors are to be heartily congratulated on the admirable way in which they have dealt with a particularly difficult subject. The various articles are of course somewhat different in style and vary in arrangement, but even this variation is beneficial as each contributor seems to have treated the country he describes chiefly according to the reasons for which travellers go thither.

As far as we have been able to ascertain the book is peculiarly accurate in its descriptions, sound in its judgments, and safe in the character of its advice. We have no hesitation in strongly recommending it to the careful consideration of all "about to travel."

A list of English medical men practising in foreign countries is given, and is likely to be of convenience to travellers wishing to be attended in case of sickness by one of their own countrymen.

The work is furnished with a good index.

We could have wished that a few maps had been included. It would have added greatly to the interest and practical value of the volume. We trust that such may be supplied in the next edition, and would suggest that the routes generally followed by travellers in search of health be clearly indicated thereon.

RIEDER'S ATLAS OF URINARY SEDIMENTS. (b)

THE publishers are entitled to the thanks of the profession for having placed this magnificent work at its disposal. Dr. Rieder's atlas, containing as it does, thirty-six plates, comprising no less than 167 figures, many of them in colours, is far and away ahead of any work of the kind with which we are acquainted. All urinary sediments of any importance are represented, only a few of the very rare ones having designedly been omitted. In

(a) "Health Abroad: a Medical Handbook of Travel." Edited by Edmund Hobhouse, M.D. Pp. 372. London: Smith, Elder, and Co. 1899.

(b) "Atlas of Urinary Sediments." By Dr. Hermann Rieder, of the University of Munich translated by Dr. F. C. Moore, Assistant Lecturer and Demonstrator of Pathology at Owens College, Manchester. Edited and annotated by Dr. A. Sheridan Depine, Professor of Pathology at Owens College and Victoria University, Manchester. London: Charles Griffin and Co., Ltd. 1899.

addition to the plates, which are works of art in their way, we have a translation of the original text, in which special stress is laid on the characters, the mode of occurrence and the pathological significance of the various urinary sediments. In respect of the inorganic or crystalline sediments it has been thought well to give some of the micro-chemical reactions because the crystalline form alone is not, in every instance, a trustworthy guide to diagnosis.

The English editors have added explanatory notes and a full bibliography, and they have been good enough to supply an alphabetical index, for which their readers will be duly grateful.

We have nothing but praise for the manner in which the translator and English editor have done their work, but the author's text is itself characterised by lucidity and even terseness. The printing of the plates leaves nothing to be desired, and since the same magnification has, as far as possible, been employed, the relative size of the various constituents is readily grasped and appreciated.

Laboratory Notes.

"TROPON."

THERE is scope in the field of what we may call scientific alimentation for palatable and readily digestible products rich in nitrogen. Dried and powdered meat, for a time, held the market, but such a product is necessarily unstable and of variable composition, and its popularity as a means of securing adequate nourishment has waned. We have just had an opportunity of examining a new, highly albuminous food, to which the name *Tropon* has been given. *Tropon* is a light-brown, almost tasteless powder, derived, we are informed, from raw vegetable and animal materials. It is not hygroscopic, and, if kept dry, is practically free from any tendency to decomposition. Our analysis of the dried powder gives the following results:—

Moisture	...	...	11.0 per cent.
Mineral matter	...	...	10 "
Albuminoids	...	...	88.0 "

which closely accords with the analyses made by others. Weight for weight it will be seen that *Tropon* contains nearly four times the amount of flesh-forming constituents present in good average meat. It is not soluble in water, but, as experiments show, it is readily amenable to the action of pepsin.

It is given mixed with milk or soup, the taste whereof is not modified thereby to any appreciable extent, though their nutritive powers are enormously enhanced.

A NEW VACCINATION IMPLEMENT.

We have received from "The Association for the Supply of Pure Vaccine Lymph" (12, Pall Mall East, London, S.W.), an ingenious innovation having for its object to supply an instrument sufficient in itself for an aseptic vaccination. It is very simple in construction and use. Briefly described, it consists of a needle with a flattened point, embedded in a glass head, the crown of which is hollowed out to receive the lymph. This, when *in situ*, is covered with a metallic diaphragm, and a cap, the whole being sealed hermetically by melted paraffin. The operation consists in scratching the arm with the point in the selected spots, then, pushing off the capsule with the thumb-nail, the glass head is applied to the skin near a place of insertion. By moving the hand with a gentle pressure the diaphragm is left behind and the vaccine should then be well rubbed into the abraded surfaces. The proportion of successes by this method is very high, ranging from 93 to 100 per cent. Asepsis is practically secured, and the chances of failure are practically eliminated. The charged needles are supplied at the price of sixpence each, the vaccine being sufficient for from three to five vesicles.

Medical News.

The Teaching of Pathology at Westminster Hospital.

THIS Institution has of late shown strong evidence of unimpaired vitality, the energy of its staff finding outlets in various directions. This we doubt not will meet with the success it deserves. Dr. Lazarus Barlow announces that he will hold the following classes in Pathology:—1. An elementary course of lectures and practical work on Monday, Wednesday, and Friday mornings from 10 to 12.30. Commencing Jan. 15th and ending in July. Fee for the whole course, £15 15s. 2. A revision class for University and other higher examinations, meeting on Tuesday, Thursday, and Saturday mornings from 10 to 12.30. Each day a lecture will be given on some selected point in pathology, and this will be followed by microscopical work. Commencing January 30th and continuing eight weeks. Fee £7 7s. Special classes will also be held in anatomy and physiology every three months for the second conjoint and hall examinations by Mr. Paton and Mr. Canny Ryall, at which students who have not passed can make the necessary attendances at these classes. Fee £3 3s. each subject. The Dean will supply full particulars.

Bradford and District Medico-Ethical Society.

THE annual general meeting of this Society was held on January 17th, 1900. The officers elected for the ensuing year were as follows:—President, Dr. J. H. Bell; vice-president, Dr. D. Goyder; hon. treasurer, Dr. F. K. March; hon. secretaries, Drs. W. Horrocks and A. Manknell; committee, Drs. Mossop, Parkinson, Bronner, Harrison, Handcock, and Metcalfe; auditors, Drs. Arnold, W. Evans, and Peck. Certain alterations were made in the rules of the Society.

A Negligent Public Vaccinator.

MR. AVERILL, the public vaccinator for the district of Longton, Stoke-upon-Trent, appears to have an insurmountable repugnance for the literary part of his functions, and at a recent meeting of the Guardians it was stated that in spite of much urging he had failed to send in any returns for over twelve months. In consequence it was decided to give him a month's notice to terminate his appointment.

University of Oxford.

THE following candidates passed at the recent examinations:—

FINAL EXAMINATION FOR THE M.B. DEGREE.

Pass List.—A. C. Goodwin, B.A., Kelle; F. P. T. Hilliard, B.A., Magdalen; F. O. Stoehr, B.A., Trinity; and J. A. Willett, B.A., University.

Pathology alone.—E. D. Bond, B.A., Kelle; J. D. Rolleston, B.A., B.N.C.; J. E. H. Sawyer, B.A., and W. V. Shaw, Christ Church; F. J. Stevens, M.A., Exeter; A. E. Thomas, B.A., Merton; and B. Warren, B.A., New.

FIRST EXAMINATION FOR THE M.B. DEGREE.

1. Organic Chemistry.—G. D. Allen, non-collegiate; G. Hely-Hutchinson Almond, Hereford; L. T. Burra, University; E. Hurstall, Trinity; v. Davidson, Brasenose; H. R. Dean, New; J. Freeman, University; R. C. Jewsbury, Christ Church; H. A. Philpot, New; E. Whitley, Trinity; and A. R. Wilson, Wadham.

2. Materia Medica and Pharmacy.—T. E. Cole, Christ Church; W. L. M. Day and A. C. Le Rossignol, Exeter College; and A. J. Wigmore, non-collegiate.

3. Human Anatomy and Human Physiology.—E. L. Farncombe, St. John's; A. H. Hogarth, Christ Church; C. M. H. Howell, Trinity; L. D. Neave, Merton; and P. F. Tine and H. M. Turnbull, Magdalen.

* Offers Human Anatomy only, being exempt from examination in Human Physiology.

Society of Apothecaries of London.

The following candidates have passed the examinations:—

Surgery.—T. P. Allen, J. R. Bentley, C. H. Brookes, A. McC. Dallas, J. M. Edwards, W. St. G. G. Hill, D. T. C. Jones, E. C. Scarlett, H. E. Weston, T. R. Wilshaw.

Medicine.—F. G. Aldrich, A. St. J. Bateman, C. H. Brookes, P. Cator, D. T. C. Jones, E. C. Scarlett.

Forensic Medicine.—C. H. Brookes, A. McC. Dallas, D. T. C. Jones, L. G. W. Tyndall.

Midwifery.—A. H. Bell, P. C. Burgess, A. A. F. Clarke, J. S. Goodall, K. Grube, D. T. C. Jones, E. R. Risien, J. Waters, H. Whitaker.

The diploma of the Society was granted to the following candidates, entitling them to practise Medicine, Surgery, and Midwifery:—

Messrs. J. R. Bentley, P. Cator, J. M. Edwards, K. Grube, W. St. G. G. Hill, E. C. Scarlett, H. E. Weston, and H. Whitaker.

Notices to Correspondents, Short Letters, &c.

✉ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

INFIRMARY NURSES AND DANCING

SIR.—An editorial with the above heading appears in the *MEDICAL PRESS* and *CIRCULAR* for January 17th, in which certain incidents are alleged to have taken place at Fulham Infirmary. May I point out that so far as *this* Infirmary is concerned the whole of the charges are absolutely baseless? Will you kindly correct the error in your next issue?

I am, Sir, yours truly,
C. T. PARSONS, M.D.Lond.

Fulham Union Infirmary,
St. Dunstan's Road, Hammersmith.
January 19th, 1906.

UN-PROFESSIONAL ADVERTISING.—Our attention has been called to an advertisement which appears in a Clonmel paper, bearing the signature of a Mr. Redington, who states that he is a Fellow of the Royal College of Surgeons, Ireland, and which puts him forward as a candidate for the position of Medical Superintendent of the Clonmel District Asylum, he being, at present, Assistant at the Richmond Asylum, Dublin. We regret to observe that it seems to be necessary for us to remind this gentleman, first that it is quite unusual for any self-respecting member of our profession to placard his election claims in the lay newspapers, and that any practitioner who does so must expect (and deservedly) the reprobation of his fellows; secondly, that the Bye-Laws of his College, which he swore to observe, prohibit absolutely this method of seeking notoriety, a fact which appears to have escaped his memory. We have, furthermore, to add that the advertisement, as it stands, would be much more suitable as the manifesto of a village stump politician than of a professional gentleman seeking a public medical office, as it places Mr. Redington's claims to appointment almost wholly on the ground of politics and religion, and lays little stress on his competency for the performance of the required duties. In our opinion, the whole thing is anything but creditable, in the professional sense, to the advertiser.

THE LIMITS OF MEDICINE.

A PREY to ill-health for many years, a certain octogenarian reproached his doctor with not having afforded him any relief. "I am sorry," replied the doctor, with a sympathetic smile, "but it is less my fault than that of your age. I can't make you grow younger." "Nor do I ask so much," retorted the patient, "all I ask is to be enabled to go on growing older for some years more."

COLONIAL SURGEON.—The facts are well known, but we doubt the expediency of acting upon them just at present.

OPTICIAN.—The custom is one better honoured in the breach than in the observance.

LAYMAN.—Our correspondent has not shown much wisdom in studying medical books.

DR. G. D. ROBINSON will find the notice he sends for publication has already appeared in our columns three weeks ago, on page 20, January 3rd.

MR. J. E. R. STEPHENS.—The matter shall be considered, and a private note sent you in due course.

MR. BASIL HALL is thanked for his communication.

THE DOCTORS' STRIKE.

ALLUDING to the action of the doctors in a certain country town where for some reason they had "gone on strike" one of the inhabitants asked anxiously what would happen. The only resource, his friend replied, is for the patients to strike too.

Meetings of the Societies and Lectures.

WEDNESDAY, JANUARY 24TH.

DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND (20, Hanover Square, W.).—4.30 p.m. Informal Exhibition of Cases. 5 p.m. Ordinary Meeting.

SOCIETY OF ARTS.—8 p.m. Mr W. O. E. Meade-King: Local Government and its Relation to Parish Water Supply and Sewerage.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square).—4.30 p.m. Dr. T. D. Savill: Lupus Vulgaris. (Post-graduate Course.)

THURSDAY, JANUARY 25TH.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.—8 p.m. Patients and Card Specimens. 8.30 p.m. Papers.—Dr. W. Edmunds: Experimental Exophthalmos and Enophthalmos.—Mr. A. Lawson: Corneal Horns.—Mr. C. H. B. Shears: Acute Glaucoma following a Single Application of Hematropine.—Mr. W. M. Beaumont: Family Tendency to Ophthalmoplegia Externa.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (20, Hanover Square, W.).—8.30 p.m. Discussion on the Treatment of Nervous Diseases and Affections by Baths and Climate (introduced by Dr. H. Campbell).

FRIDAY, JANUARY 26TH.

CLINICAL SOCIETY OF LONDON (20, Hanover Square, W.).—8.30 p.m.

Papers:—Mr. J. Hutchinson, jun.: Two Cases of Successful Primary Resection of Gangrenous Small Intestine.—Mr. Pearce Gould: A Case of Bullet Wound of the Abdomen with Four Wounds of Small Intestine and Two of the Mesentery, Operation, Recovery.—Dr. Rolleston: A Case of Fatal Hæmopneumothorax of unexplained origin.

Appointments.

CLEGG, J., M.B.Lond., M.R.C.S., an Honorary Medical Officer to the Urmoston Cottage Hospital.
DINGWALL, A., M.B., C.M.Aberd., Medical Officer for the Kinsham and Pembroke Sanitary District of the Kingston Union.
JENKINS, HERBERT, L.R.C.P.Lond., M.B.C.S., House Surgeon to the Bristol Royal Hospital for Women and Children.
LEADER, HAROLD, M.B., House Physician to the East London Hospital for Children and Dispensary for Women, Shadwell.
QUAYLE, EDWIN, L.R.C.P.Lond., M.R.C.S., an Honorary Medical Officer to the Urmoston Cottage Hospital.
SAUNDERS, E. SYMES, M.D., C.M.Aberd., Medical Officer to the Dispensary, Royal Albert Hospital, Devonport.

Vacancies.

Bath General or Royal Mineral Water Hospital, Bath.—Resident Medical Officer, unmarried. Salary £100 per annum, with board and apartments.
Birr Union.—Trained Fever Nurse. Applications to the Clerk of the Union before February 3rd. Salary £40, with board and lodging. (See Advt.)
Chester General Infirmary.—Visiting Surgeon for two years. Salary £80 per annum, with residence and maintenance in the house.
City of Liverpool.—Visiting Physician to the City Hospital North,etherfield Road. Salary £130 per annum. Applications to the Town Clerk, Liverpool.
Croydon.—Medical Officer of Health for the Borough. Salary commencing at £500 per annum. Apply to the Town Clerk, Town Hall, Croydon.
Loughborough and District General Hospital and Dispensary, Loughborough.—Resident House Surgeon. Salary £100 per annum, with furnished rooms, attendance, and board.
Metropolitan Asylums Board.—Three Assistant Medical Officers at the Fever and Small-pox Hospitals, unmarried. Salary commencing at £160 per annum, with board, lodging, attendance, and washing. Applications to the Clerk to the Board, Norfolk Street, Strand, London.
Nottingham City Asylum.—Second Assistant Medical Officer, unmarried. Salary £125, with board, apartments, and washing.
Nottingham General Dispensary.—Assistant Resident Surgeon. Salary £140, per annum. Special arrangement made as to board &c.
Nottingham General Hospital.—House Surgeon for two years. Salary £100, rising £10 a year to £120, with board, lodging, and washing.
Plymouth Borough Asylum. Assistant Medical Officer, unmarried, Salary £125 per annum, rising to £150, with furnished apartments in the Asylum, board and washing free.
Salisbury Infirmary.—House Surgeon, unmarried. Salary £100 per annum with board, lodging, and washing.
Western Dispensary, Rochester Row, Westminster.—Resident Medical Officer, unmarried. Salary 100 guineas per annum, with furnished rooms, coals, gas, and attendance. Apply to the Secretary.
Worcester General Infirmary.—Assistant House Surgeon and Dispenser for two years, unmarried. Salary £70 per annum, with board, residence and washing.

Births.

BRODIE.—On the 16th inst., at Fernhill, Wootton, Isle of Wight, the wife of C. Gordon Brodie, F.R.C.S., of a daughter.

Marriages.

BRIDGEFORD — CUMBERLAND.—On December 13th, 1899, at St. George's Church, Victoria, Australia, Walter Bridgeford, M.R.C.S.Eng., L.R.C.P.Ed., of Boulder, W. Australia, to Florence, daughter of the late Capt. R. F. W. Cumberland, Manchester Regiment.

PLUMMER—MOXON. On January 17th, at St. Nicholas Church, Great Yarmouth, Selby W. Plummer, M.D., of Durlam, to Jillian, daughter of the late Thomas Hy. Moxon, M.R.C.S., of Great Yarmouth.

Deaths.

BRADY.—Killed in action at Kimberley. Geo. C. Brady, son of the late G. Frazer Brady, M.D., F.R.C.S., of Falcarragh, Co. Donegal.

COLLUM.—On January 12th, at Surbiton, Robert Collum, M.D., M.R.C.S., M.B.C.P., aged 84 years.

MANBEY.—On January 13th, at Stanley Villa, Stanley Road, South Acton, George Manbey, M.R.C.S.

ROBERTS.—On January 12th, at the Hawthorne, Croyley Green, Herts, John Henry Roberts, F.R.C.S., in his 87th year.

VERNON.—On January 20th, at his residence Southport, Hy. Hannote Vernon M. Ed., M.R.C.S.Eng., Medical Officer of Health for Southport, aged 68.

WATLINGTON.—On January 19th, at 1, Randolph Gardens, London, N. W. Y. Victor Watlington, M.D.Ed., of Puerto Rico.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXX.

WEDNESDAY, JANUARY 31, 1900.

No. 5.

Original Communications.

THE CO-RELATION OF SEXUAL FUNCTION WITH INSANITY AND CRIME. (a)

By H. MACNAUGHTON-JONES, M.D.,
M.A.O., M.CH., &c.,

President of the British Gynaecological Society.

(Concluded from page 80.)

CLIMACTERIC INSANITY.

CLIMACTERIC insanity occurs both in men and women, but, as Clouston has shown by his statistics, in a much larger proportion of women, 196 to 32 out of 228 cases. The ten years from forty to fifty are the ones he regards as most favourable to the development of the insanity. It is, he says, a sub-acute psychosis, as mania is not nearly so common as melancholia, and suicidal impulse occurs in fully 50 per cent. of the cases, an important practical point being that such suicidal impulse is difficult to prognose so far as the intensity of the suicidal desire, and that such patients have to be always surrounded by every care and precaution against the impulse.

It is interesting to note the pathological changes that occur in senile ovaries, when alluding to that form of insanity that Clouston calls ovarian, which occurs in old maids, the combined effects of an unprepossessing appearance, with a too great devotion to religious exercises, "severely virtuous in thought, word, and deed," "in whom nature, just before or after the climacteric, takes revenge for too absolute a repression of all the manifestations of sex."

Otroschkevitch has shown that in old age the epithelium covering disappears from the surface of the ovaries, that there is desiccation of mature, and wholesale degeneration of the primordial follicles, attended by hyaline degeneration of the arteries and the fibrous tissue, and finally fatty degeneration of the cellular tissue. Here we must have a corresponding decrease in the ovarian secretion.

Here is a case in point. A lady, unmarried, and passing through the climacteric, was brought to me for the removal of a comparatively small uterine polypus. For some time her manner had altered towards her relatives, and she was more taciturn and morose, but there had been no direct evidence of any marked mental alienation. I determined to remove the polypus, but was so struck with the manner of the patient, that in placing her in the Medical Home I asked the superintendent to obtain a special mental nurse to look after her. The next morning she was taking her breakfast, nothing whatever having occurred in the meantime to excite suspicion, and while the nurse was placing something outside the bedroom door, having foolishly allowed a knife on the tray, the patient cut her throat in two places, fortu-

nately not fatally. I subsequently removed the growth in an asylum, but I am not aware that she ever recovered her sanity.

To show how persistent and obscure, with long intervals of suspension, these climacteric impulses may be, I may mention the case of a lady, sent to me by the late Dr. Hack Tuke, who had prolapse of the uterus, with attendant bladder symptoms. She suffered at times from marital delusions and attacks of melancholia. The prolapse was cured, and the patient relieved. She was supposed to be completely cured, but some years later, without any warning, in a fit of depression she committed suicide by drowning.

Clouston places under a separate heading "hysterical" insanity, an insanity engrafted on hysteria, and groups under this a distinct class of symptoms, such as incessant talking, sexual and erotic ideas, imaginary ailments, craving for notice, habits of masturbation. He says such cases form 50 per cent. of insane females.

I am not referring to-night to puerperal insanity, further than to say that in considering the etiology of this affection, various workers have shown that both in uterine lesions which have existed previous to labour, and the other affections of pregnancy, we have ante-partum warnings of the predisposing causes of this affection, while in lesions occurring during labour, such as severe laceration of the cervix, not treated immediately and rectified, we have the exciting causes of the puerperal mania. The insanity of pregnancy Clouston regards as comparatively rare, occurring in women advanced in life when becoming pregnant, and usually of a melancholic and suicidal character.

There is an important bearing on these cases, as indeed, on all cases of insanity in women, and that is the hereditary alcoholic tendency and proneness to alcoholic nerve degenerations and dipsomania. Sixty per cent. of such cases, Clouston says, recover at childbirth. How far menstruation, epilepsy and insanity are correlated, may be still further deduced from the observations by Sutherland in Hack Tuke's "Dictionary of Psychological Medicine." Briefly, they are as follows:—Esquirol has computed that the disorders of menstruation form one-sixth of the physical causes of insanity, and in this conclusion Morel coincides. In epileptic insanity the catamenia has a marked influence on the fits, increasing these in number or intensity. Menstruation has a like effect in producing exacerbations of excitement in mania, while in sufferers from melancholia, amenorrhoea is frequently present. General paralysis appears to induce an early climacteric, and further, the curious fact is recorded that in a few aged insane women, the catamenia reappear after prolonged cessation. It is worthy of notice that in dementia, menstruation does not appear to be affected, and all the evidence points in the direction that there is a delay in the appearance of the menstrual act in imbeciles, idiots, and cretins.

I have recently had two patients, sisters, both of

whom developed symptoms of insanity. In one it assumed the form of dislike to the parents and delusions regarding them, as well as a suicidal tendency. The first attack occurred with suppression of the catamenia. She quite recovered from this. With a second stoppage of the periods she became the victim of religious delusions. Again, with the re-establishment of the catamenia, she has perfectly recovered. The other sister with the onset of each menstrual period grew excitable, and incoherent, and took sudden violent dislikes even to her parents. This mental derangement passed off about a week after the termination of her rather scanty flow. Gradually approaching the next epoch it recurred. She is now perfectly well, and her uterine functions are healthy.

Clouston well sums up the class of symptoms we meet with in patients of this stamp. I may summarise them as follows:—Stupidity and lethargy in some, lack of interest in duty, an anti-social tendency, causeless aversion to relatives, intolerance of control, incompatibility of temper, impracticable visionary scheming and want of common sense; sudden development of unaccountable immorality, or perverted sexual and reproductive trains of thought. Unfortunately, as the writer says, such patients, who really require to be placed in the hands of a doctor, too often find their way into the arms of a policeman.

I have myself recorded two cases which, so far as I know, are unique, of trophic disturbance associated with menstruation. One, which I brought before this Society, 1896, of deep discolouration and pigmentation of the entire side of the face, complicated occasionally with extensive ecchymosis of the cellular tissue of the orbit, in a case of violent dysmenorrhœa, and coming on with the catamenia. The other, which I read elsewhere, and to which I gave the name of "esthiomenic menstrual ulcer of the nose," in which the most serious trophic disturbances, resulting in a form of corroding ulcer of the nose and lip, recurred with each menstrual period, and began with amenorrhœa. Curiously enough, a sister in the same family was subsequently troubled in like manner. The full particulars of the case I refer to were in the *Edinburgh Medical Journal*, 1898.

Hack Tuke (a) in writing on marriage and insanity, notices what he evidently regards as a perversion of feeling, in which young persons of both sexes suffer during a protracted engagement from a revulsion of feeling, and an antipathy is engendered which may lead to a rupture and its legal consequences. Of course, there is one powerful factor in both men and women, which, especially during the development of adolescence, has a strong collateral influence in producing and maintaining erotic desires, impulses, and delusional insanity. Of this I have myself known some marked instances. I allude to the practice of masturbation. Not only has this habit a predisposing influence in the direction of such morbid emotions or delusions, but in many cases it plays a principal part in the production of the epilepsy of puberty.

I can speak from personal knowledge, having had many consultations with him in cases of mental trouble associated with disordered sexual functions, as to how the late Hack Tuke regarded this question. He recognised fully the coincidence of disordered menstruation and disturbance of the mental functions, but was not greatly impressed with the value of a surgical operation on the insane, though, as he stated in the discussion which took place in this Society ten years since, he considered that the operation of oöphorectomy might be indicated in certain cases, and justifiably performed with benefit.

Our distinguished Honorary President on the same occasion held that in cases of nervous derangement, in which disorder of the sexual functions is suspected,

a close investigation as to the state of the sexual organs should be made. There can be no doubt that the view of Spencer Wells, speaking generally, was against operation in such cases. Dr. Savage, in 1890 at that discussion, held that a relatively small amount of success followed examination of the pelvic organs of women. I have had, for the purposes of this address, a valuable letter from Dr. Blandford, whose long experience of the insane makes any opinion emanating from him of special value, and in that—for I have not here time to quote the entire communication—speaking from his forty years of connection with insane cases, the view is strongly upheld that uterine or ovarian disorders are not serious factors in the causation of insanity. He has never had a case of malignant uterine disease, and in only one patient a fibroid tumour, which was developed years after the insanity. He looks upon the cessation of the catamenia and amenorrhœa as rather a concomitant occurrence than as having anything to say to the causation of mental disease, and with regard to operations, he says that he has never known a patient cured by one, and has known insanity to follow in one case. He does not approve of subjecting a woman in a maniacal state to a vaginal examination.

I quote this opinion as expressing, on the part of an experienced alienist, the views of those who are strongly antagonistic to the more modern school, both of alienists and gynecologists, with regard to this question. As one holding possibly what I might call a middle position, I refer to a communication I have had from Dr. Percy Smith, of Bethlem, who also took part in the discussion of 1890. His views are the same now as then. He considers that the number of women in asylums who are supposed to have reached them through diseases of the sexual organs is greatly exaggerated; and, further, that many of the cases which have been admitted to Bethlem Asylum had already been submitted to gynecological treatment for affections of the genitalia, and that the breakdown had come during such treatment and after operation for the local disease. He thinks, in cases of recurrent insanity and where the disorder is most marked at each menstrual period, that while he has no experience of the effect of oöphorectomy, it is worthy of consideration in cases where outbreaks of eroticism, excitement, or stupor, occur at each period, the patient being sane in the intervals; and the amenorrhœa, which is present in acute mental disorders, he regards, in the greater number of cases, as a symptom of the general disorder, and does not believe that it demands a local examination. Nor does he in any way agree with the American suggestion that every woman admitted to an asylum should be examined, regardless of age or symptoms. "The gynecologist must not lose sight of the nervous system, nor the alienist of the pelvic organs."

Dr. Yellowlee, writing to me, says that gynecological operations for the cure of insanity are far from satisfactory in their results, and are not justifiable unless there be proof that there is local disease irrespective of the insanity.

I myself have seen insanity (not climacteric) complicating fibromata, displacements, and adnexal disease—but in every case the history disclosed a pre-existing predisposition to mental obliquity or some distinct form of alienation. Personally, I at present take the view that, in the great majority of cases in which there are gross lesions of the sexual organs present in insane women, and even where the lesion has preceded the insanity, there still has been pre-existent to the lesion what Robert Barnes well calls "an antecedent nervous condition as a predisposing factor."

I lately operated upon a young lady who had been previously confined in an asylum, and who subsequently had the operation of supravaginal hysterectomy performed. The latter step was taken for a fibroma of the uterus, and the adnexa of one side were removed. The discharge from the cervix continuing, and treatment not availing, she consulted me for the affection of the cervix. On examination I found a most unhealthy cervix with a deep and bleeding erosion, and a rather profuse discharge. I removed the cervix, and she recovered perfectly from the operation. But the old symptoms of erotic mania returned, and it became necessary to remove her to an asylum from which she has since been discharged as cured.

I operated upon another case—one of a lady who had held the office of superintendent in a private asylum, and from whom I removed two cystic ovaries. She previously had had curettage twice performed for endometritis and erosion of the uterus. She complained of constant agonising pain in the seat of the ovaries, and dysmenorrhœa. She was a typical specimen of the true neurasthenic and neurotic woman. Not until I had emphatic requests in writing from herself and relatives did I consent to operate, nor would I confess, be in a hurry to accede even under these conditions to such a proposal in a similar case. Twice she deliberately induced a hernia of the wound by her own acts, necessitating a third operation and forcible restraint afterwards to prevent a repetition of this, and then so admirably feigned a condition of dementia that not until the certificates for removal to an asylum were filled, which were really completed in order to test her malingering, did she return to a natural state of mind. This case, though an unenviable experience to me, may, perhaps, be a warning to others.

Mr. Elder and Mr. Furneaux Jordan have both had two cases of post-operative insanity, all of acute mania. The operations were curettage and oöphorectomy, and the diseases ovarian cystoma and myoma.

One of our Fellows, Dr. Halliday Croom, has this year reported a case of acute mania occurring on the third day after simple ovariectomy, the patient dying on the sixth day, and also a second case of acute mania at each menstrual period, which he treated several years since by the removal of cystic ovaries, resulting in a permanent cure.

Elzholtz, of Vienna, has reported a case of suicidal melancholia completely cured by pan-hysterectomy. In this case there was a bleeding myoma. (a)

I have also through Mr. Martin notes of a case. A patient, æt. 42, upon whom he operated in the Warwick Asylum for ovarian tumours, suffered from melancholia, which passed into dementia. The case ended in complete recovery. He refers to two other instances of menstrual mania which were cured by pan-hysterectomy. In the one case four years, in the other two, have elapsed since the operation, and both have completely recovered. On the other hand, he also sends me notes of two cases, one of vaginal hysterectomy for chronic metritis and hæmorrhagic endometritis, and the other a case of pan-hysterectomy for myoma, in both of which insanity followed the operation, one about a week, and the other three weeks, later.

Dr. Japp Sinclair gives me the particulars of an interesting case of a lady who had been confined in the Cheate Royal Asylum. She suffered from a bleeding fibro-myoma, and had been subjected to a long course of expectant and old womanly treatment for the same. Professor Japp Sinclair performed hysterectomy, and though there was an anxious time after the operation, she never again had to return to

the asylum, from which she had been temporarily removed for the purpose of operation.

Dr. Ernest Hall reports another most interesting and instructive case. The patient suffered from intermittent melancholia for nearly three years, and came to be looked upon as a hopeless case in the London Asylum (Montreal). The adnexa when examined, after she had been in the asylum from April, 1895, to January, 1898, were found diseased. Complete recovery followed on oöphorectomy.

Professor Auguste Martin, of Berlin, on whose vast experience I thought it well to draw in writing this address, says that all his experience teaches him that healthy women do not run the risk of insanity from their sexual functions, nor are they endangered as to insanity by operations on their sexual organs. On the other hand, if their mental condition at the time of the operation or previously, be not a normal one, operations on the sexual organs induce mental instability or temporary insanity, the more so in proportion as their physical or mental state have been impaired prior to the operation.

Dr. Wood, of Hoxton, out of eleven cases, admitted to the asylum within ten years, of women who suffered either from climacteric disturbances, or in whom sexual disturbance was attributed as a cause, shows that in one case melancholia had followed removal of the ovaries, in another it supervened after suppressed menstruation, and in another, a senile, prolapsus uteri was present. There was one case of mania of pregnancy, one of the mania of puberty, and six of climacteric insanity. Up to 1890 Keith had six cases of insanity out of 64 hysterectomies, and Savage of Birmingham had records of four cases of insanity out of 483 cases of oöphorectomy.

Mary Dixon Jones, whose opinion as unquestionably the foremost of living women gynecologists, and whose views with regard to epilepsy I have already quoted, (a) referring to oöphorectomy for diseased ovaries and tubes in the case of women so affected who are insane or mentally afflicted, having instanced some such cases, says: "I would not remove healthy or normal ovaries for dysmenorrhœa or any suffering in the regions of the ovaries; I would not remove any save diseased adnexa for epilepsy, nor for mental or neurotic disease, even if I had failed after long trials of tentative measures, and had the cordial, full, and deliberate sanction of experienced practitioners."

George Rohé, of the Hospital for the Insane, Sykesville, who probably as much as any other living psychologist has studied the effects of the operation on women in insanity, and, indeed, also in the case of males, comes to these conclusions with reference to post-operative insanity, that while there is little difference in the two sexes between the number affected, the graver forms follow, in the majority of cases, operations upon the abdominal and pelvic organs in women. He considers that, excluding cases of heredity, or acquired psychopathic predisposition, the mere removal of the ovaries would have no greater psychical effect than the removal of the arm or leg.

Confusional insanity is the form frequently found as post-operative, and both Dr. Rohé and Dr. Hurd of Baltimore, who has written on post-operative insanity and undetected tendencies to mental disease, consider that the great majority of the cases are due to toxæmia from septic infection. "There is no ground for considering," says Dr. Hurd, "that the operation *per se* produces mental disease," and, so far as removal of the ovaries is concerned, a premature climacteric insanity may be developed, but this is due to the loss of the organs, and not to operation." The essential pre-requisite for the development of post-

(a) Vienna Klein Wochenschrift, November 23, 1898.

(a) "British Gynecological Journal," November, 1895.

operative insanity must be in all cases a neurotic organisation predisposed, either from hereditary taint or from acquired nervous weakness, to take on diseased action in consequence of any disturbing influences. Operation should be discouraged in people of this constitution.

Mr. Jesset inclines to this view, that though insanity may occasionally follow gynaecological operations, still, the rule is that the patients recover from the mental disturbance and are ultimately much better for the operative interference.

It was my intention to have referred to other matters in which gynaecology is brought into close relationship with forensic medicine, and where it plays a most important part, as, for instance, in suspicions of chastity and the form and condition of the hymen; gonorrhoea, and the presence of the gonococcus in uterine discharges, and the whole question of scientific pathological evidence as regards wounds of the uterus, the condition of the endometrium, the presence and duration of the products of conception in utero, as well as the pathological differentiation of pregnant and non-pregnant changes in the ovaries. All these considerations seriously affect a correct decision in cases of attempted or produced abortion. Time, however, does not permit of this.

CONCLUSIONS.

On the entire evidence before me, I have come to these conclusions (1) That the correlation of insanity and disordered sexual functions arising out of affections of the generative organs is a factor to be taken into serious consideration in the treatment of women mentally afflicted.

(2) That where there is ground for the suspicion that some physical condition of the uterus or adnexa exists which may produce or aggravate the mental affection, a careful examination, under an anæsthetic if necessary, should be made.

(3) That in the investigation of criminal acts committed by women, either during the menopause or while the menstrual function is either active or suppressed, due weight should be given to the influence exerted by its irregularity or abeyance on the mind of the woman. In doing this, her previous history and temperament have to be considered.

(4) That the special dangers of the climacteric period and the symptoms indicative of threatening climacteric mania must be recollected. The principal of these are moroseness and depression of spirits, attacks of hysteria, occasional hallucinations of sight and hearing (especially of smell), suspicions with regard to relations, unjust dislikes, unfounded apprehensions of some great crime committed or injury inflicted on them, suicidal tendencies. Here again examination of the pelvic viscera is justifiable.

(5) That in operations on the female generative organs there is a greater predisposition to mental disturbance than after other operative procedures, but the post-operative insanity is generally of a temporary nature.

(6) That women who have been previously insane are predisposed to a relapse by the development of disease in their sexual organs, and especially to such temporary recurrence of insanity after operation on these organs.

(7) In order to anticipate suicidal impulse, and the commission of crime, the disordered mental symptoms exhibited at the menstrual epochs and at the climacteric should be carefully noted, and if the discharge or the cessation of the sexual function be attended by evidence of disease in the sexual organs, an examination of these should be made, when, if gross lesions be detected, operation should be resorted to.

A RARE FORM OF ULCERATION IN THE FEMALE URETHRA. (a)

By RICHARD DANCER PUREFOY, M.D.Dub., F.R.C.S.I.,

Master of the Rotunda Hospital; Obstetrical Surgeon to the Adelaide Hospital, &c., &c.

THE close resemblance in aspect and clinical history between some forms of chronic syphilitic disease and others of a malignant nature, has long been recognised—indeed, sometimes the effect of treatment by drugs must be observed before the differential diagnosis can be safely established. Especially is this observable in regions where cutaneous and mucous structures coalesce, and hence the external female genitals, as might be expected, furnish some of the best illustrations of this fact. A young woman, who recently was under treatment in the Gynaecological Wing of the Rotunda Hospital, complained of pain and soreness in the vagina, and on examination the following conditions were observed:—The greater labia were of normal size and healthy. On the inner surface of the left nymphæ a circular excavation existed, the edges sharp-cut and overhanging; the base, white, cicatricial tissue. The entrance of the vaginal canal was closed by a morbid growth, with nodulated surface of a deep red colour, which, on close examination, proves to be an out-grow h hanging from the edge of an enormously dilated urethra; indeed, the lower third of this passage was so widened and distorted, that considerable difficulty was experienced in passing a catheter into the bladder. Strange to say, the patient, in spite of this, did not suffer from incontinence of urine. In the vestibule and adjoining parts an indolent shallow ulceration was observed, alternating with patches of white cicatricial tissue marking its former course. Dr. Purefoy said: In the writings of the late Dr. West I had long ago observed some records of cases so closely, if not absolutely identical, with the one under consideration that I do not hesitate to quote some of his remarks. He says:—"The affection has come six times under my observation—twice in married women, who acknowledge to having suffered from venereal disease; and four times in women of unchaste life, one of whom was at the time suffering from a secondary syphilitic eruption. In each instance the patient alleged that she had either been aware of the ulceration or had for some time suffered from painful and difficult micturition. Twice the disease was associated with excrescences from the mucous membrane of the urethra. The ulceration appears to begin at the orifice of the urethra, extending thence inwards towards the bladder, producing in its course a great widening of the canal and a patulous condition of its orifice, so that the finger tip can easily enter it, while the surface is the seat of large indolent granulations which secrete a small quantity of muco-purulent fluid, are not generally very tender to touch, but highly sensitive to the passage of urine."

I have met with this ulceration independently of any other disease in these parts, but also in cases where previous ulceration had destroyed the clitoris and the nymphæ, and have seen it associated with unhealthy ulceration about the posterior commissure of the labia and the entrance to the vulva, as also with those small condylomatous growths about the vulva which one often meets with in cases of vascular tumour of the urethra, and these latter, indeed, are far more commonly present than absent. When the disease has advanced far, or has been of long standing, the cellular tissue beneath the urethra

(a) Read before the Royal Academy of Medicine in Ireland, January 5th, 1900

usually becomes considerably thickened, and I have seen the lower wall of it represented by a dense cartilaginous substance, not unlike one of the lips of a hypertrophied and partially procident cervix uteri, while on two occasions I have been able to carry my finger along the whole length of the canal into the bladder. Even when not far advanced this disease causes difficulty in the retention or actual incontinence of urine, while, when it has extended along the whole canal, and left its aperture permanently patulous, the sufferer may be afflicted with complete incontinence. In one such case I have seen, the patient, *æt.* 22, had suffered from the infirmity for many months. She was afforded some slight relief and comfort by wearing a pessary, which, by pressing against the urethra, partly closed it. In another such case the ulcerated canal was so widely open that two fingers could be easily passed into the bladder. In its earlier stages this distressing affection admits of some amelioration by local measures—the application, for instance, of oxide of zinc in the form of ointment, or lotion with liquor plumbi; and, even in the advanced stage, attended with widening of the urethra, the use of strong nitric acid, or the actual cautery, may bring about such cicatrization and attendant contraction of the diseased parts that control of the bladder may be regained. Some facts in the history of my patient, as well as some scaly patches on the face and neck, afforded such presumptive evidence of a syphilitic taint that I prescribed for her a combination of bichloride of mercury and iron in mixture, and its use was followed by marked improvement, though I cannot be sure of its permanence. In many points these cases bear a close resemblance to that formidable disease of the female genitals first described in 1849 by M. Hugnier, and to which he gave the name “*lupus hypertrophicus, or perforans*.” This affection is very rare; I have myself only once seen it, and medical literature does not afford records of more than about forty cases in all. In the admirable “*Memoirs on Diseases of Women*,” by Dr. M’Clintock, will be found excellent illustrations of some of them. Whatever views we entertain as to their pathological history, they serve, I think, to enforce the remark with which I began this short communication.

FIVE CASES OF ANGINA PECTORIS.

By DR. SALOMON,
of Berlin.

I HAVE recently had under observation five well-marked cases of angina pectoris, which present several points of interest. The symptoms were alike in all. At first a painful sensation was complained of behind the upper part of the sternum, so severe as to compel the patient to relinquish whatever he was doing, and seek support. After a variable interval the distressing sensation was repeated. There were no asthmatic symptoms in any of the cases. In the course of a few weeks the pain began to radiate to the left arm, and soon the patient found it almost impossible to go upstairs. Finally even gentle movements, such as undressing and getting into bed, started the pain. Some months later an attack came on of the most agonising pain, taking the breath away with a feeling as if death were imminent. The duration of such attacks was from ten minutes to several hours. The attacks usually recurred at shorter and shorter intervals. One patient, however, had only a single attack and another did not have a well-marked attack at all.

Case I. died suddenly during an attack; he had suffered from syphilis.

Case II. was that of a gentleman, *æt.* 58, who was

intemperate, and was suspected of having had syphilis. The attack came on at constantly diminishing intervals day and night. Morphia only gave ephemeral relief. Ultimately maniacal attacks came on and he died.

Case III. was that of a man, *æt.* 53; the attacks were probably started by influenza. There was no history. He also died, and sclerosis of the coronary arteries was found after death.

The next two patients recovered. A man towards the end of the fifties was accustomed to immoderate exertion, both physical and mental. He had one attack which lasted 24 hours. This was four years ago. He gradually lost the sternal pain on walking, and became able to take long walks and climb hills without inconvenience. Case V., a patient also in the fifties, was a neurasthenic in consequence of venereal excesses. He also recovered after several attacks of moderate severity, and has been well for two years.

Sclerosis is the recognised cause of the disease, but a good deal depends on its situation and degree. We meet with angina, dependent on ischæmia of the heart, a condition which obtains in aortic regurgitation and stenosis. Sée never recognised a pseudo-angina of nervous origin.

Sée’s views and his treatment by the iodide was fully recognised in Germany. Previously treatment was purely hygieno-dietetic. For the attacks themselves we had ether, chloroform, amyl nitrate, nitroglycerine, morphia subcutaneously, &c. But recovery cannot be effected by these medicaments, and although the attacks may thereby be shortened or ameliorated, death was still the usual sequel. It was only with the introduction of the iodides by Huchard in 1883 that a serious attempt was made to prolong life. Iodines are supposed to strengthen the cardiac muscle and to dilate the blood vessels, and Huchard reported a number of striking recoveries under treatment with the iodine salts, and he assumed that they had a resolvent effect on the arterio-sclerotic process. According to Sée, however, the vascular lesion continued unchanged, as evidenced by numerous autopsies. He concluded that the beneficial effect was due merely to the action of the medication on the circulation as a whole.

Among German authors Vierordt, from being an opponent, became a warm advocate of the iodide treatment, and at the Medical Congress of 1897 he reported a number of really remarkable successes. Treatment should be continued for at least a year, and should be resumed at intervals afterwards. Vierordt believed in a positive curative effect of the circulating iodine, particularly on the walls of the blood vessels.

Personally, I do not believe that iodine can do any good in genuine cases of ordinary angina. There is an angina with a neurasthenic base, which in its symptomatology and its prognosis differs from that of coronary angina, and in my experience patients with coronary angina die, while those with neurasthenic angina get better.

The treatment is not affected by the distinction, for iodine along with the hygieno-dietetic treatment must always occupy the first place.

AMBROISE PARÉ AND HIS TIMES.

By J. GRANT ANDREW, M.B., C.M.,
Assistant-Surgeon to the Victoria Infirmary, Glasgow.

THE following sketch of the great French surgeon, Paré, is based on material derived from the classical monograph of Malgaigne and the admirable biographical study of Mr. Stephen Paget. Paré was born in 1510 and died in 1590, so that his life was

practically co-extensive with the century. Paré was surgeon-in-ordinary to four French kings, and among the more notable of Paré's contemporaries were Luther and Erasmus, Calvin and Knox, Shakespeare and Rabelais, Raphael and Titian, Montaigne, Paracelsus, Servetus, Sylvius, and Vesalius. During the Dark Ages the ban of the Church on the dissection of the human body had arrested pathological research and development in surgery, with the result that the great mediæval surgeons can be counted on one hand. The rediscovery of the literature of the ancients, which partly caused and partly followed the Renaissance and the revolt against prescriptive authority, imparted new life to the study of surgery. Paracelsus, with all his charlatanry, was a beneficent iconoclast, and Paré, on the experimental side, was the great pioneer of sinner methods of operative surgery and regimen. Paré was born at Bourg-Hersent, in Marne, his father being, according to one account, "coffretier," or maker of wooden chests; according to another, valet-de-chambre and barber to the Seigneur de Laval. Ambroise had a sister, Catherine, who married Gaspard Martin, a master barber-surgeon of Paris. His education was irregular and elementary. He says, quaintly:—"I desire not to arrogate to myself that I have read Galen either in Greek or Latin, for it did not please God to be so gracious to my youth that it should be instructed in the one tongue or the other."

An opportunity which Ambroise had of "assisting" an eminent surgeon from Paris, who came to the village to perform an operation, fired him to try his fortune in Paris, and since his brother-in-law was a barber-surgeon there Paré set himself to learn surgery. There is no record of the circumstances of his student life beyond the fact that, while still unqualified, he was lucky enough to get an appointment at the Hôtel Dieu as house surgeon where he continued three years, accumulating a vast store of data for future use, one of his teachers being the great anatomist, Sylvius. After leaving the hospital Paré did not settle down to spend his life in a barber-surgeon's shop for a practice to grow up slowly. He had too much ambition and energy for that. It was a stormy age of frequent wars, and Paré resolved to live a double life—with the army in times of war, at Paris in the intervals of peace. Accordingly we find him present at every campaign until 1569, when he ceased to wander, and lived quietly, but industriously, at home, one of the most familiar and best-beloved citizens of Paris. He died about Christmas, 1590, just after Henri IV. had raised the siege of Paris, which, in respect of the frightful suffering which it caused, has been compared to the siege of Jerusalem by the Romans. We know nothing of the manner of Paré's death.

War has always had its horrors, but in this scientific age it is difficult to conceive of the monstrous inhumanities rife in Paré's times. We owe his description of these, and of the more humane methods of treatment which he introduced, to the mere accident that he was attacked in his old age by a preposterous Dean of the Faculty of Medicine, who asserted that Paré's use of the ligature after an amputation was vastly inferior to the old-established use of the cautery. "The book was an idiotic appeal to authority and tradition; the very thing that Paracelsus would have loved to burn. But it has an everlasting merit, inasmuch as it drew from Paré his 'Apologie et Traicte contenant les Voyages faicts en divers Lieux.' This work, which is remarkable for rich humour, pungent wit, and shrewd observation of the facts of disease, and of men and affairs, gives an account of Paré's campaigning experiences, and of the lessons he drew from them, and casts many instructive sidelights on the manner and customs of medical and surgical practice in the sixteenth

century. The thesis of his defence being the superiority of ligaturing and soothing treatment for hæmorrhage and gunshot wounds, &c., to the orthodox methods of the actual cautery and boiling oil. He naturally gives much attention to the miseries of the wounded under the prevailing system. One passage will serve as a sample of his quality:—"The soldiers within the castle, seeing our men come on them with great fury, did all they could to defend themselves, and killed and wounded many of our soldiers with pikes, arquebuses, and stones, whereby the surgeons had all their work cut out for them. . . . I had read in John de Vigo

. . . that wounds made by firearms partake of venenosity, by reason of the powder, and for their cure he bids you to cauterise them with oil of elders, scalding hot, mixed with a little treacle; and, to make no mistake before I would use the said oil, knowing this was to bring great pain to the patient, I asked first, before I applied it, what the other surgeons did for the first dressing, which was to put the said oil, boiling well, into the wounds, with tents and setons: wherefore I took courage to do as they did. At last my oil ran short, and I was forced instead thereof to apply a digestive made of the yolks of eggs, and turpentine. In the night I could not sleep in quiet, fearing some default in not cauterising, that I should find the wounded to whom I had not used the said oil dead from the poison of their wounds, which made me rise very early to visit them, where, beyond my expectation, I found that those to whom I had applied my digestive medicament had but little pain, and their wounds without inflammation or swelling, having rested fairly all night; the others, to whom the boiling oil was used, I found feverish, with great pain and swelling about the edges of their wounds. Then I resolved never more to burn thus cruelly poor men with gunshot wounds." Paré then relates how he paid court to a surgeon of Turin to discover his secret and sovereign balm for gunshot wounds. He succeeded, and was much gratified to find the recipe, which was to boil in oil of lilies young whelps just born and earthworms prepared with Venetian turpentine, "was like that which I had obtained by chance."

One of the cures upon which Paré dwells with venial pride will have a peculiar interest for pharmacists as an example of the sixteenth-century drugging. By command of the king, Paré attended M. d'Auret, a Flemish nobleman, who was almost moribund with a suppurating gunshot wound in the thigh. Paré very naively remarks that when he saw that the patient was so ill he was very sorry that he had come, for his own reputation. In consultation with the staff of physicians and surgeons who had been treating d'Auret for seven months, Paré prescribed a course of treatment which is only partly indicated in the following extracts:—"For the bedsores . . . a fresh soft bed, with clean shirt and sheets. For the swelling and coldness of the limb hot bricks, sprinkled with a decoction of nerval herbs in wine and vinegar, and to the feet an earthenware bottle filled with the decoction. The thigh and the whole of the leg to be fomented with a decoction made of sage, thyme, lavender, flowers of chamomile and melilot, red roses boiled in white wine, with a drying powder made of oak-ashes and a little vinegar and half a-handful of salt. For the bedsores a large plaster made of the desiccative red ointment and of Ung. Committissae equal parts. . . And for the strengthening of the heart a refrigerant of oil of water lilies, ointment of roses, and a little saffron dissolved in rose-vinegar and treacle, spread on a piece of red cloth. For the syncope . . . good nourishment full of juices, as raw eggs, plums stewed in wine and vinegar, broth of the meat of the great (stock) pot, the white meat of

fowls, partridges' wings minced small, and other roast meats easy to digest, as veal, kid, pigeons, partridges, thrushes, and the like, with sauce of orange, verjuice, sorrel, sharp pomegranates; or he may have them boiled with good herbs, as lettuce, purslane, chicory, buglass, marigold, and the like. At night he can take barley-water, with juice of sorrel and of water-lilies, of each two ounces, with four or five grains of opium, and the four cold seeds crushed, of each half an ounce. . . . For the great pain in his head his hair must be cut and his head rubbed with rose vinegar just warm. . . . also a forehead cloth of oil of roses and waterlilies and poppies, and a little opium and rose vinegar, with a little camphor, all wrapped in a handkerchief, to be held some time to his nose. . . . And we must make artificial rain, pouring water from some high place into a cauldron, that he may hear the sound of it, by which means sleep shall be provoked in him. . . . For the knee, ointment of mallows and oil of lilies, and a little *eau-de-vie* and a wrapping of black wool with the grease left in it." It is evident from this example that Paré possessed one of the chief secrets of success in medical practice—he was a master of minutia; but while, probably, some of the details were introduced for the sake of their dramatic or moral effect, Paré did not omit the essentials, which were the opening of the abscess and the administration of opium, along with careful dieting. The use of opium in an age which esteemed powdered unicorn's horn a panacea and crushed mummy "the sovereignest thing on earth for an inward bruise" is significant of Paré's bias towards more rational modes of treatment. The last book that Paré wrote was in denunciation of the craze for mummy. "Ambroise will have none of it, 'flesh of decomposed, cadaverous, dead bodies.' He has never seen it to do anything but give the patient a pain inside and make him sick. The ancient Jews, Egyptians, and Chaldees never dreamed of embalming their dead to be eaten by Christians. . . . It smells so bad that fishermen use it for bait. . . . Nobody is sure what it really is. Some people believe that mummy is made and manufactured in our own France, and that they take the bodies, by night, off the gallows, eviscerate them, dry them in an oven, dip them in pitch, and sell them for good, true mummy, saying they bought them of Portuguese merchants, who brought them from Egypt." He then tells the story of a friend of his who visited a storehouse of mummies, owned by a Jew, at Alexandria. Asked if the bodies had been brought from the sepulchres of the ancients. "The Jew fell a-laughing and mocked at this . . . saying that it was not four years since he had prepared all these bodies himself, thirty or forty, and they were the bodies of slaves and such-like people. He did not care whence they came, nor what they died of, nor whether they were young or old, male or female, provided he got them, and nobody could tell who they were once they were embalmed, and he marvelled greatly that the Christians were so greedy to eat the bodies of the dead."

Considering the activity and vicissitudes of his life, Paré was a prolific writer. His writings, according to the custom of his time, range over a wide variety of subjects in anatomy, surgery, medicine, obstetrics, State medicine, pathology, pharmacy, natural history, and demonology. Many of his treatises brought him into violent conflict with the Faculty of Medicine, which controlled the whole profession at that time. The interests of the three leading branches of applied medicine were represented by (1) the corporation of barber-surgeons, which had worked its way up from the position of a craft to a quasi-professional footing; (2) the confraternity of surgeons; and (3) the Faculty of Medicine, which stood for the physician

proper. These institutions were perpetually engaged in a sort of triangular duel. Paré began his career as a member of the corporation of barber-surgeons. He underwent two examinations, but it is not clear whether they were two separate examinations or whether Paré failed the first time he went up. When Paré became distinguished by his skill and his Court appointment, he naturally wished for a better professional status, and he sought to enter the confraternity of surgeons, and they were so eager to have him that they plunged into a labyrinth of irregularities, and, although they made a pretence of ploughing him, he was admitted soon after, and it was understood that the examination was merely formal. His enemies of the Faculty never allowed him to forget that he had been smuggled into the fold; but the great grievance which that body had against him was that he wrote his books in the vernacular, and even when he got some of them turned into Latin they were not propitiated, but Paré held his own against them, and sometimes outflanked all their forces.

While Paré's works contain much sound doctrine on the subjects with which they deal, they also reveal the limitations of his age. "He had no knowledge of the circulation of the blood or of the absorbent system, no anæsthetics, no antiseptics, no bacteriology; his understanding of the nervous system was not in advance of his times, and he had neither microscope, nor stethoscope, nor thermometer." Paré believed that the stars influenced the course of disease, that the plague came of itself by the Divine will, apart from Nature, as a punishment for the sins of the people, although he endeavoured to trace its natural causation, that maggots in wounds and many other living things were generated spontaneously. He believed in the devil, evil spirits, sorcery, and witchcraft, and in the power of saints to cure disease. He had a firm faith in the royal touch for the king's evil. As an offset to these superstitions, we find that "some of his operations were curiously modern. He understood and practised what we now call massage, he had a good way of producing local anæsthesia, he was opposed to immoderate bleeding, he knew the value of rest and silence for his patients."

In his private character Paré presents many engaging aspects. He was sociable, peace-loving, humane, and the friend of the poor. In some respects he was very like his illustrious successor, John Hunter, whose maxim "Why think? Why not experiment?" was the keynote of Paré's method. "They both of them began life in the country, they saw something of war, and wrote on gunshot wounds. . . . They spent the money lavishly when it came, they were great lovers of animals and their ways. . . . They loved the collecting of specimens, dissecting them, demonstrating them. . . . But there are two points of special likeness between them—first, the constant appeal to experience; next, the love of questioning, comparing notes, getting to know the results obtained by other men. Paré rashly predicted that the surgical advances of his time had left little for posterity to improve upon, and now his own methods are antiquated, his theories all wrong, his books are the forgotten treasures of a few great libraries. Our methods, our explanations, will also be superseded; our books, many of them, will not even be treasured. He has kept his hold for three centuries by force of character, and that alone."

THE Queen has sent through Lady Addington a beautiful quilt to the Buckingham Nursing Home. The article is not only valuable, but it is also interesting from the fact that it was worked by Her Majesty.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, JANUARY 26TH, 1900.

SIR R. DOUGLAS POWELL, Bt., President, in the Chair.

MR. J. HUTCHINSON, JUNR., read a paper on

RESECTION OF GANGRENOUS INTESTINE IN CASES OF HERNIA.

He related two cases of successful primary resection of small intestine during herniotomy, both operations being performed by simple enterorrhaphy without mechanical aids. One was a woman with a strangulated femoral hernia on whom he had operated in 1893, removing five inches of damaged gut, she was in good health six years later. The second case was a man with strangulated inguinal hernia, in this it was necessary to excise ten inches of intestine, this was done by Maunsell's method—that is one in which an artificial intussusception was made. The patient made a perfect recovery, but died three years later from ulcerative colitis, and the specimen was fortunately obtained for Mr. Hutchinson by Mr. H. L. Barnard. It was shown at the meeting, and proved that there had not been the slightest narrowing at the site of the resection. Mr. Hutchinson remarked that it was probably the general impression that the use of Murphy's button had rendered resection of intestine not only quicker, but safer. To test this belief he had collected from hospital records (including all the cases he had himself operated on both with and without this apparatus), fifteen examples of primary resection for gangrenous gut performed with Murphy's button, and sixteen cases in which suturing alone was employed. Of the former only one (seven per cent.) had recovered, of the latter six (forty per cent.). This was a very striking comparison, but besides this the fatal cases treated by suturing alone had lived on an average twice as long as those in which Murphy's button had been used; in other words, they had given so much more promise of survival. Three out of the ten fatal cases of simple suturing would probably have recovered but for accidental complications (multiple strictures of small intestine, obstruction of intestine by an omental band, and tuberculous phthisis causing constant cough). Moreover, the post-mortem records showed, on the whole, better union of the divided ends after suturing than after the use of Murphy's button. The latter was apt to cause acute congestion by its bulk, its weight was also a disadvantage, and even should the patient recover it was probable that a stricture might result. At any rate, the openings made by operations with Murphy's button in gastro-jejunostomy sometimes showed a marked tendency to contract. The greater time required for the accurate performance of suturing did not appear to be of much practical importance—it had probably been a little exaggerated. The after-shock had not been dangerous in his experience. Whilst primary resection of [gangrenous, perforated, or irretrievably damaged intestine in a hernia must always be attended with high mortality, it yet offers the best chance of recovery. Of eleven such cases treated by other so-called conservative methods—formation of an artificial anus, &c.—every one had died. This agrees with the results previously brought forward by Mr. Kendal Franks, Mr. C. B. Lockwood, and other surgeons. Turning to the details of the operations, in performing resection it was of great importance to excise enough of the damaged intestine so that the sutures might be placed in healthy tissues, and it was nearly always advisable to do it through a median abdominal wound. Special care had to be taken with the mesenteric ends of the two ends, for leakage most readily occurred at this point. Maunsell's method was probably one of the best to employ. If the intestine could be emptied and made to contract this would favour sound union and tend to prevent infection of the stitch apertures by the septic contents. It was probable that the administration of an aperient immediately after the operation would lead to

better results than in the past. The author had operated on 140 cases of strangulated hernia with a total mortality of 25 per cent. Sixty-five were inguinal herniæ, of which fifty-four recovered; fifty-four were femoral, and of these forty recovered; whilst twenty-one were umbilical, and of these twelve recovered: taking all the fatal cases together, thirty-four deaths in all, 25 per cent. The great majority were due to the gangrenous or acutely inflamed condition of the intestine and omentum at the time of operation. Five of ten fatal cases were possibly due to the employment of too conservative methods.

Mr. BARKER said he much preferred primary resection to the use of Murphy's button, which he thought was merely a phase in the evolution of this class of operation. He pointed out that the amount of intestine removed was a matter of no great importance, the essential element of success being that the suture should be applied to healthy gut, the walls whereof had not been injured by distension. He related three cases of intestinal suture of his own. In one the button dragged the intestine into a kink and caused death. In two others he sutured with excellent results without even a bad symptom, but he was careful to resect far away from the seat of the original lesion.

Mr. HOWARD MARSH remarked that excision of the intestine for gangrenous intestine was not nearly as dangerous an operation as was generally supposed, but he agreed that it was necessary to remove the intestine from a sufficient range so that no untrustworthy part was included in the suture.

Mr. CHARTERS SYMONS observed that the statistics of the operation would no doubt improve, because in future they would probably operate in a much larger proportion of cases. The great difficulty in his opinion was to empty the intestine, thus preventing continuance of the symptoms from subsequent paralysis of the bowel. He expressed himself in favour of direct suture, and concurred in the views expressed adverse to the use of Murphy's button.

Mr. HUTCHINSON, junr., in reply, said he had used sutures of fine silk going through all the coats. He remarked on the fact that they found no adhesions of any sort of that part of the intestine or on the corresponding part of the peritoneum, the scar being absolutely smooth. He was unable to suggest any novel method of emptying the bowel, and remarked that if some means of doing so could be devised the operation would be greatly simplified. He, too, had been struck with the superiority of the direct suture in gastro-jejunostomy, the cases not exhibiting any tendency to contraction at all.

MR. A. PEARCE GOULD read a case of

BULLET WOUND OF THE ABDOMEN, WITH FOUR WOUNDS OF THE SMALL INTESTINE AND TWO OF THE MESENTERY: OPERATION: RECOVERY.

The patient was a young German, æt. 20, who was accidentally shot with a small revolver on the evening of October 30th, 1899. A doctor who was called to him at once found him in great pain and administered an hypodermic injection of morphia, and then took him on to the Middlesex Hospital where he was seen by Mr. Pearce Gould about an hour after the accident. The wound in the abdomen was 2 ins. below the navel and 1 in. to the left of the middle line. There was still some pain; the respiration was easy and the abdomen moved freely; pulse 96. The liver dulness was not obliterated, no dulness in either flank. No paralysis; 6 ozs. of clear normal urine were drawn off by catheter. Under an anæsthetic the wound was explored and found to extend into the peritoneal cavity. This was freely opened and blood flowed out from it, but neither gas nor intestinal contents were observed. The intestine was examined, and four wounds apparently in the jejunum were found, three of these were perforating, the other involved the serous and muscular coats only. There was no visible escape of intestinal matter. These wounds were closed with Halsted's sutures of sterilised silk, and two wounds of the mesentery which were close by were also sutured. No other lesion was found. The peritoneal cavity was cleansed, the bowel returned and the abdominal wound closed. The man made an uninterrupted recovery, and left the hospital.

well, on December 4th. The bullet was found lying deep in his left buttock and was left alone. In commenting on this case Mr. Pearce Gould drew attention to the following points:—1. The multiple lesions produced by a single bullet. 2. The absence of symptoms of the granular lesions. 3. The necessity for exploration, even in spite of the absence of all symptoms, to determine whether the wound was perforative, whether any viscus or large vessel was injured and, if so, to treat them. He emphasised the importance of the hypodermic injection of morphia immediately after the accident, both in relieving pain and shock, and in controlling the movements of the intestine and so lessening the chance of fouling of the peritoneum with germ-laden intestinal contents. The case illustrated the necessity for careful and thorough exploration of the abdomen (by operation) in all cases of perforating wound and severe contusion of the abdominal wall.

The PRESIDENT remarked that the case was one of great interest to both physicians and surgeons. Although the administration of opium and morphia had, not without reason, been discarded in these cases, he pointed out that it was one thing to give them while the diagnosis had yet to be made, and quite another to administer them after the diagnosis had been made clear. With a bullet wound through the abdomen they might take it for granted that the abdomen had been injured, so that there was not the same objection to the use of morphia in such cases in view of the relief to suffering which it procured, especially on the battlefield. They were invaluable in perforations and the like. He suggested that the absence of shock in the author's case was largely due to the patient's being under the influence of morphia.

Mr. BARKER commented on the fact that some patients with severe abdominal injuries suffered severely from shock, while others scarcely suffered at all. He remarked that the results in these operations must greatly depend on the time they were taken in hand after the injury. If seen at once every surgeon he supposed would explore, but if not seen until after a lapse of time doubts might be entertained. He thought that small bullets with high velocity might pass through the abdomen without inflicting necessarily fatal injury. He concurred in the view that opium was at present left too much in the background.

Mr. HOWARD MARSH referred to two cases of his own, one that of a boy who had been run over by a cab who exhibited no symptoms of shock, &c., and this induced him to abstain from operating. The lad died next day, and then he was found to have sustained a ruptured colon. In the other case a gentleman while hunting was thrown on to a heap of stone, and was severely shaken. Nevertheless, he remounted and rode home, went the next day to London, and it was only on returning home that he fell into a state of collapse and died, when it was found that he had sustained an injury of the superior mesenteric artery causing gangrene of the bowel. He insisted on the value of saline injections to overcome shock in these cases.

Mr. NEWTON PITT called attention to the fact that veterinary surgeons were the habit of puncturing distended intestine through the abdominal wall with a large trocar usually without any disastrous results. He recalled the report of a case which had recently appeared in which a soldier had received a bullet right through the abdomen in which nothing was done, yet the man recovered. If an exploratory operation could be done under favourable circumstances he would do it, but not otherwise.

Mr. GOULD, in reply, said the patient was only partially under the influence of morphia. He suggested that the difference in the amount of shock must be due to some physical cause. In his own case it was the small intestine and the mesentery close to the intestine that were injured, so that the deeper nervous plexuses escaped injury. Possibly the absence of shock was due to this fact. He agreed that saline injection were often useful, but in this case the condition of the patient did not appear to call for it. On the whole he thought that experience of puncturing the intestine in man was un-

favourable to the practice. He admitted that if they operated in every case they would alight on a certain proportion in which there was no perforation of intestine but as against these there were the cases in which grave injury was unaccompanied by serious symptoms, and he thought the balance was in favour of routine exploration.

ROYAL ACADEMY OF MEDICINE IN IRELAND SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, JANUARY 5TH, 1900.

The President, Dr. A. V. MACAN, in the Chair.

SPECIMENS EXHIBITED.

DR. PUREFOY.—A case of ectopic gestation removed by vaginal coeliotomy, with microscopical section showing chorionic villi.

MULTILOCULAR OVARIAN TUMOUR.

Dr. ALFRED SMITH showed a multilocular ovarian tumour which he removed from a patient aged thirty-five. The patient was seized with severe abdominal pain and acute distension, with much distress. Examination under ether demonstrated uterus free, and a tumour the size of a full-term uterus, which would not come down to the pelvis; no pedicle could be made out. Diagnosis doubtful. Operation revealed a tumour distended with blood; pedicle acutely twisted. No adhesion had formed. Recovery.

SYPHILITIC PLACENTA.

Dr. HEARD, of Monkstown, exhibited a specimen of above.

Dr. PUREFOY insisted on the interest of the association of albuminuria with a state of health which could only be removed by the use of mercury, and the albuminuria made that fraught with danger.

Dr. SMITH thought the condition of the intima of the arteries must be known before they could determine whether the placenta was syphilitic or not.

Dr. JELLETT asked was the quantity of albumen large, and had the woman suffered during pregnancy or before it?

On the motion of Dr. MONTGOMERY the specimen was referred to the Committee of Reference for decision as to whether it was syphilitic or not.

Dr. GLENN exhibited a specimen of intraligamentous myoma removed by coeliotomy.

DECIDUOMA MALIGNUM.

Dr. W. J. SMYLY, in a paper on deciduoma malignum, reviewed the literature of the subject, pointing out that observers were now almost unanimous in believing that this was a disease sufficiently distinct to merit separate consideration. They also agreed as to its clinical features, pathological appearances, and treatment; also as to its connection with pregnancy, and differed only as to their views concerning its histogenesis. Having reviewed the various theories upon this subject, he said that in the present state of our knowledge it was impossible to determine which view was correct, but he inclined to Veit's opinion, that the disease was a sarcoma, modified by pregnancy. He also described a case which had come under his own observation. The patient, a pluripara, was delivered of a hydatiform mole in December, 1898. She had repeated hæmorrhages until May 10th, when she had so profuse a hæmorrhage that she was reduced to a condition of profound anæmia. The uterus was dilated, and a quantity of material resembling placenta removed, which, on microscopic examination, proved to be deciduoma malignum. Putrefaction and septic fever followed, with pulmonary symptoms and empyema preceding radical measures. She lingered two months and then died. There was no post-mortem examination. Dr. Smyly showed the microscopic specimens at the Edinburgh meeting of the British Medical Association, when they were pronounced by Dr. Sanger to be typical examples of the disease which he had described.

Dr. PUREFOY said he had never felt the tissue of the

uterine wall in such a condition of utter degradation and softening as it was in this case. It felt like brown paper. The mole structure removed on the first occasion was of a nature not commonly seen in these cases. He thought it was mixed fleshy and hydatiform mole. Scattered through it were distinct vesicles, evidence of vesicular degeneration being also present.

Dr. SMITH said he was inclined to regard it as an ordinary sarcoma influenced by pregnancy. He knew some eminent pathologists who thought it an ordinary sarcoma. The whole literature of the subject was embodied in Dr. Smyly's excellent paper.

The PRESIDENT said there was one case not mentioned by Dr. Smyly—i.e., Pick's case, in which he found the metastasis of the ordinary hydatid mole not to be malignant. Pick considers that the fetal structures are only accidental, and they may even form embolisms without being malignant. Opposed to Veit's opinion (which most people would agree with) was that which regarded it as carcinoma of the outer layers of the epithelium covering the villi.

Dr. SMYLY replying, said the point about metastasis in cases of hydatiform mole was one of extreme practical importance, because anyone who had not learned otherwise would think that when metastasis occurred the case was hopeless. But the metastasis might not be malignant; a woman might have benign meta-stasis in her lungs and recover after operation. Of course, if there were malignant metastases the case would be perfectly hopeless.

A BARE FORM OF ULCERATION IN THE FEMALE URETHRA.

Dr. PUREFOY read a paper on this subject which will be found on page 106.

In the discussion that followed, Dr. SMITH asked what was the difference between this condition and prolapse of the mucous membrane of the urethra?

The PRESIDENT said he specially asked the question as to whether the orifice of the urethra was in the centre, because the same idea had occurred to him as to Dr. Smith. The ulceration seemed to be very much like the ulceration that took place in prolapse.

Dr. PUREFOY, in reply, said that if the President and Dr. Smith had seen the case they would not put forward the opinion that it was prolapse. It had no character in common with that condition. Some of the tissue was whitish, and of almost cartilaginous hardness. The outline of the urethral canal was perfectly distinct. The tissue was entirely different from the ordinary mucous lining of the urethra, and was associated with and continuous with cicatricial tissue.

The Section then adjourned.

SHEFFIELD MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD THURSDAY, JANUARY 18TH, 1900.

The President, Dr. BURGESS, in the Chair.

Dr. ARTHUR HALL introduced a case showing the remains of vaccination pustules on the "chapped hands" of a girl, *et. 15*, who had not previously been vaccinated. She had nursed a recently vaccinated baby about a month previously.

Dr. VINCENT showed a specimen of adenoma of the kidney from a patient who had died of apoplexy.

Dr. RISELEY read the notes of a case of

ABSCESS OF THE BRAIN FOLLOWING INJURY OF THE EYELID.

The patient was a boy, *et. 1*, who was admitted to the Royal Hospital, Sheffield, on October 20th, suffering from an abscess in left upper eyelid. The lid was very prominent, dull red and glazed looking, and there was a small wound with sloughy edges and distinct fluctuation. Three weeks previously the child had run a rusty sharp-pointed file-maker's tool into the eyelid for about an inch. The wound did well for a time and then began to swell up. The lid was incised transversely on admission, an excessive amount of pus escaped, and on introducing finger bare bone was felt. The wound was plugged with iodoform gauze. Temperature remained

subnormal and child apparently did well till the second night, when meningitis set in, temperature rose to 100, and the patient died within 12 hours of onset of symptoms. Towards the last the eyeball could be seen apparently quite normal. There was escape of cerebro-spinal fluid from wound. Post-mortem: Fracture of orbital surface of frontal bone. Lymph covering brain on upper and under surfaces. An abscess on under surface of frontal lobe size of large walnut, communicating through the fracture with wound of lid. The abscess cavity contained a little pus and some iodoform crystals and was lined by pyogenic membrane.

Dr. N. BARDSWELL read a report on eight months' trial of

THE SANATORIUM TREATMENT OF PHTHISIS

at the Sheffield Royal Infirmary. Accommodation had been made for twenty patients, but the conditions under which the trial had been made were disadvantageous. In the grounds hammock chairs for the patients and a revolving shelter had been erected for accommodation in bad weather. Routine treatment had been for the most part modelled on that followed at Nordrach. Apyrexial cases spent the whole day in the grounds, those with pyrexia lay by open windows, the wards being well aired throughout the night. Three chief meals were given, viz., at 6 a.m., 12.30 and 7 p.m., extra butter, milk, and eggs being added to the infirmary "full diet," the diet being modified for individual cases when necessary. Carefully regulated walking exercise was allowed in cases with a temperature never above 100.2. Pulmonary gymnastics were also employed in convalescing cases, systematic massage replacing exercise in bad cases. Practically, no medicines were given except bitter tonics, and cod-liver oil and malt. Temperature was taken every four hours in the axilla, the pulse and respiration were recorded night and morning. The sputum was measured and recorded every day in drachms, the weight was recorded weekly. In all thirty patients had been treated, eighteen of them being still in the Infirmary. The cases were unselected. By far the best results had been obtained in patients with a small amount of active disease, and good general condition. Out of seventeen such cases five had been nearly cured, and returned to suitable work, and the rest were very much improved in every respect. Cases with extensive, active disease, and severe constitutional disturbance, and those with phthisis laryngea had done badly, half of them dying, and the rest improving in the summer to remain stationary or to relapse in the winter. As far as Sheffield Infirmary was concerned nearly all the patients improved considerably under treatment from April to September, but during the winter months all cases, except those with small lesions, and those who were well advanced towards convalescence, either ceased to improve or became worse.

BRITISH LARYNGOLOGICAL, RHINOLOGICAL, AND OTOLOGICAL ASSOCIATION.

MEETING HELD FRIDAY, JANUARY 12th, 1900.

Dr. BARCLAY BARON, President, in the Chair.

THE PRESIDENT showed an obscure nasopharyngeal case. A middle-aged man, after having a discharge of pus and blood from the nasopharynx and deafness for several months, began to suffer from severe paroxysmal pain in the right side of the head, becoming gradually worse and more extensive. Later, there was numbness of the skin of the same side of the face. Examination revealed a small, hard, circumscribed swelling with a smooth surface in the upper part of the nasopharynx.

After a few remarks by Mr. Mayo Collier, Mr. WYATT WINGRAVE said that he could detect a hard swelling apparently on the internal pterygoid plate, which was suggestive of a new growth.

Mr. J. BARK (Liverpool) related a case of painful spasm of the muscles on one side of the face, cured by removal of a nasopharyngeal polypus.

Mr. WYATT WINGRAVE showed a case of lupus of the

fauces, with extensive ulceration extending down to the larynx, causing much destruction of tissue.

Dr. R. Woods (Dublin), expressed a doubt as to the case being lupus, and advised specific treatment. Mr. Mayo Collier gave reasons for similar views, and Mr. Wyatt Wingrave replied.

Dr. DUNDAS GRANT showed (1) a case of emphysema of the orbit in a labouring man due to blowing the nose. (2) A case of laryngitis secondary to rhinitis. (3) A case of bridge-like synchiae between the septum and the inferior turbinal body without ascertainable cause. (4) A case of lupus of the inferior turbinal.

Dr. FURNESS POTTER showed. (1) A woman, æt. 47, with postnasal growths which he considered to be persistent adenoids. After giving his reasons for this view he mentioned other cases of postnasal growth in adults which had proved to be malignant. (2) A case of a growth on each ventricular band in a man, æt. 39. (3) A case of extensive papillomatous growth of the vocal chords.

Mr. ATTWOOD THORNE showed for Dr. WILLIAM HILL a case of stammering in a youth.

Dr. DENNIS VINRACE thought that, the cause being neurotic the treatment indicated was careful tuition with avoidance of attempts at conversation when excited, and attention to the general health.

Mr. MAYO COLLIER advised the removal of the adenoids present, and exercise for the thickened palate.

Mr. ST. GEORGE REID observed that in some cases where the velum was sluggish and pendulous, and articulation indistinct it was advantageous to remove a small piece of its posterior edge.

Dr. BROWN KELLY (Glasgow) read a paper upon

EPISTAXIS FROM THE ETHMOIDAL VEINS.

He reported several cases of severe epistaxis in which the stream of blood had been traced to the septum above the anterior end of the middle turbinal. He showed that the vessels ruptured were probably the anterior ethmoidal veins, and that these are closely connected with the intra cranial circulation. The absence of valves in the veins and the pressure in the longitudinal sinus would allow of a profuse flow in a backward direction. Hæmorrhage from this source are easily checked by packing gauze between the middle turbinal and the septum anteriorly.

Mr. J. BARK (Liverpool) observed that recurrent epistaxis in adults usually occurred in the position indicated by Dr. Kelly, and that a small plug inserted between the middle turbinal and the septum was effectual and caused little discomfort.

Dr. R. Woods alluded to the constitutional treatment of such cases, supplemental to local measures. Mr. Mayo Collier and the President also joined in the discussion.

Dr. R. Woods (Dublin) showed a skiagraph of a foreign body in the œsophagus of a child, which was successfully removed.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, January 27th, 1900.

RHYTHMIC TRACTIONS OF THE TONGUE,

At the Académie de Médecine M. Laborde spoke on the mechanism of the respiratory reflex and tractions of the tongue. If upon the living animal, he said, moderately anesthetised, the trunks of the superior laryngeal nerves were excited, a more or less intense agitation with incoherent respiratory efforts would be observed ending, if the irritation continued, in the arrest of the respiratory movements. On the other hand, by exciting the central end of the pneumogastric nerves in an animal placed experimentally in a state of asphyxia, or of apparent death, a return of the respiratory movements was witnessed, so that under this new condition the intervention of the irritating cause provoked and brought back the functional activity instead of producing its suspension

or arrest. He had applied from that fact a double application of mechanical methods of traction of the tongue, namely, the rhythmical or intermittent traction when it was a question of awakening and of maintaining the suspended respiratory reflex; continued traction when it was necessary to obtain the arrest of a morbid hyperactivity such as spasm of the diaphragm constituting hiccough.

M. Pinard said that when a child was apparently still-born he introduced the tube of Chaussier into the larynx after having removed all the mucus from the region and practised artificial respiration. Immediately the heart began to beat more frequently, and in successful cases vermicular movements were observed in the diaphragm, and finally the first inspiration, followed quickly by others thus establishing definitely the function. Consequently, and without wishing to detract anything from the experiments of his colleague, he was of opinion that it was the air alone which acted upon the heart first and the respiration afterwards.

M. Laborde answered that he was far from wishing to ignore the efficacy of insufflation of air into the trachea in children apparently still-born, but it was, nevertheless, true that in individuals profoundly asphyxiated, rhythmical tractions of the tongue succeeded where insufflation of air failed. It was for that reason, and also relying on his personal researches, that he thought he was authorised in saying that the first method was more efficacious than the second, and was of more easy application. He did not condemn, however, insufflation of air, and thought it should be employed concurrently with traction of the tongue when possible.

ABSCESS OF THE LIVER.

M. Lucas communicated a case of abscess of the liver in a man who had lived in Algeria ten years, where he had contracted the disease which terminated in abscess. On his entry into the hospital the patient was in a miserably cachectic condition, fever, sweats, &c. Suppuration of the liver being suspected an exploratory trocar was passed in at a selected point giving issue to 500 grammes of pus. After having resected the ninth and tenth ribs behind, the speaker incised the abscess and withdrew nearly three pints of matter. The seat of the suppuration was then washed out with oxygenated water, two drains were placed *à demeure* and the wound closed. At present the patient is as well as might be expected, and although he was operated on rather late, there was a good chance of definite recovery. As to the instrument chosen for incising the liver Dr. Lucas said that he always used the thermo-cautery instead of the knife; the former was more tedious, but the loss of blood was reduced to a minimum.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, January 27th, 1900.

THE PROPHYLATIC TREATMENT OF PUERPERAL FEVER.

Prof. DÖDERLEIN in a paper in the *Therap. Monatsch.* strongly advises the use of india-rubber gloves in cases where manual interference is necessary as well as the usual means for insuring absolute cleanliness. Treatment has not, he says, gone hand in hand with bacterial knowledge, nor has it advanced equally with prophylaxis, but it has distinctly advanced with the aid of

bacterial knowledge. In all cases of puerperal infection the infective germs can be demonstrated in the interior of the uterus. The variation in the clinical symptoms depends on the variety of bacteria and their poisonous qualities. One thing, however, is constant, the temperature and the cardiac activity form the first and most exact indication of the condition. These objective signs render possible a timely causal method of treatment.

If one proceeds on the assumption that the primary disease is in the uterus, by the time these symptoms above named show themselves, the bacteria will already have invaded the tissues, the lymph tracts, the glands and blood vessels, where they can be further followed up. There appears, therefore, a prospect of fighting the infection only when the uterus can be properly cleared out and disinfected in the first stages of the disease. Opinions, however, are not at one as to the best way of doing this. We scarcely know what remedies are effective, but one thing we do know and that is that on account of their dangerous qualities we must abstain from such highly poisonous antiseptic solutions as sublimate and carbolic acid. Ahlfeld had recently recommended alcohol, and the writer had made use of a 96 per cent. solution.

As regards antistreptococcus serum, his experience, contrary to that of many, had been favourable, and, for the future, he would not omit its employment in any case of streptococcus infection. The remedy was, however, of use only against infection with streptococci, so long as no deleterious consequences of a general or local kind had taken place.

As regarded symptomatic treatment, in his opinion, the free employment of antipyrin was the most trustworthy. In certain rare cases total extirpation of the uterus recommended by Schultze was justifiable and successful. In illustration of this he reports two cases in which he performed the operation with success.

At the last meeting of the Free Society of Surgeons, Hr. Weber read a note on

SUBPHRENIC ABSCESSSES.

Of 600 cases of perityphlitis seen in the Moabit Hospital there was suppuration in 300 and in nine the abscess was subphrenic. In six cases the vermiform appendix was situated under the liver, the cæcum dragged upwards. He thought the fact of importance as regarded the origin of subphrenic abscesses. Besides the recognised ways along the colon and behind the peritoneum, there was a third way in which pus could reach the subphrenic space.

The pleura was implicated in all the cases, in seven there was empyema, and in two dry fibrinous pleurisy. In all the cases but one the pus was intraperitoneal. The speaker was of opinion that subphrenic abscesses could be avoided if extensive incisions were made so that the whole field of disease could be brought into view. The abscess was opened in most cases through the pleura; in those where the pleura was not affected after the costal pleura had been sutured to the diaphragm.

Hr. Sonnenburg followed with a paper on

THE TREATMENT OF CIRCUMSCRIBED ABSCESSSES OF THE PERITONEAL CAVITY.

Riedel, of Jena, had recently published a work on this subject, in which he laid down the principle that the abdomen should be opened at once as soon as fever set in

and a palpable tumour was present; he went carefully over the abdomen, held back the intestines with gauze, opened the abscess under the protection of compresses, and carefully wiped away every trace of pus; he then closed the abdomen in layers, but leaving the skin unsutured, and allowing a strip of gauze leading from the abscess cavity to the outside to remain in the angle of the wound.

The speaker did not think the procedure worth being copied; it was quite certain that the healthy peritoneum could bear much more than was formerly suspected, and that only irritated peritoneum was incapable of resisting infection. The question only was the peritoneum near the abscess to be looked upon as healthy. In the majority of recent cases he should say no; an inflammatory irritability was here set up by toxins, and a few bacteria would be enough to bring about suppurative peritonitis. It seemed therefore better to wait until the stage of irritation was past and firm adhesions had formed. Then it was advisable to get into the abscess as directly as possible, sparing the adhesions, clearing the cavity, and then closing the wound. It was here there was danger of ventral hernia, but it was safer than to close the wound, and if hernia did occur it would be operated on at a later stage without danger.

Hr. Karewski had lately had two subphrenic abscesses not of perityphlitic origin, one had its origin in osteomyelitis of the 11th and 12th ribs. The other case was that of a child who was run over, and was admitted with symptoms of general peritonitis. Under expectant treatment the condition improved, but in four weeks it got worse again and a subphrenic abscess developed which was opened through the pleura. In the abscess the whole of the spleen was found broken up and mixed with blood. The pus was sterile. Recovery took place.

Hr. Körte during the last 10 years had treated 35 cases of subphrenic abscess, of which 23 recovered; 16 started in the vermiform appendix, of which 11 got well. The inflammation in the appendix could run itself out, as was shown by some sections where nothing but residue of an old inflammation could be found in the part. He did not believe toxins could set up peritonitis; in all cases of peritonitis examined bacteria were found in the pus. A palpable tumour in a case of suppuration in the abdomen was a good sign, and indicated that adhesions had formed, but in itself it was not an indication for immediate operation, but rather for further waiting unless the condition called for immediate interference.

Hr. Londner had been led to the conclusion to attack all intraperitoneal abscesses, he was convinced that the peritoneum could take care of minute traces of secretion. His results had been so good that he saw no reason to alter his methods of treatment.

Hr. Sonnenburg explained that toxins could set up fibrinous peritonitis, but not the purulent form.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, January 27th, 1900.

MEDICAL DISCUSSION AND PAPERS IN LAY JOURNALS.
At the first meeting of the "Gesellschaft der Aerzte"

for 1900 the president, Prof. Chrobak, had a large number of invited guests, among whom was His Excellency, Von Hartel, Secretary of State, &c., whom he warmly greeted. In opening the session he said there was one thing that pained him deeply, and had often been condemned as unseemly in our profession which he hoped the members of this institution would endeavour to eradicate, viz., the publishing of medical subjects in lay papers. This was sadly to be deplored, but if individual members would assist him, he thought this degradation could be averted, as the blame lay in their own ranks, and not in the public.

He further added that he was asked by the Minister of Justice to give a categorical answer to the following questions, which he would read to the meeting:—(1) Do you consider the the Berne Convention with the Paris additions of any use to Austrian authors in literature, art, and photography; also what are the objections? (2) Should these branches be combined, or should any one receive preference to another? (3) Would the interests of the author, publisher and public be equally served by their union, or would this injure education? These questions were relegated to a committee for answer.

INJURY TO KIDNEYS AND BLADDER.

Weinlechner next showed a number of interesting cases, such as tabetic swelling at the knee-joint, with genu valgum; spontaneous fracture of the neck of the femur with hyperostosis; dermoid in buccal cavity. A young man, æt. 27, who fell from a scaffold and tore the right kidney; fever ensued, after which he operated removing the injured organ, with perfect recovery and urine elimination of 1,890 grammes, equalling 63·1 ounces.

Another case of a similar nature was that of a boy who fell from a tree, tearing the bladder, from which the urine passed into the rectum; at the same time, paresis of the detrusor vesicæ, sphincter ani, and both extremities were produced. He performed *sectio alta*, sewed the torn bladder and bowel, since when the continence of the urine has been entire, with an improvement in the paresis of the detrusor and sphincter ani muscles.

MEDICAL EXAMINATIONS.

The new regulations of the medical faculty have now been published by the Minister for Education which have excited a wave of criticism. Exner read a long paper to the "Gesellschaft" which was loudly applauded. Albert asked if this meeting had no power in the arrangement of these subjects, or was its province simply confined to debating them.

To his mind the whole examination was now confined to cramming the youth with a number of scientific facts without an opportunity of proving them. Supplementary theory for practice was surely a mistake. "Drill" and science was once the watchword of medicine, but theory without practice was now sufficient. The subjects were further postponed for discussion.

TRACHOMA.

At the "Doctoren Collegium" Hans Adler discussed the present treatment of trachoma, in a long paper, commencing with the history of the disease down to the bacterial research of which he said there were now 18 microbes assumed in the transmission of the disease. These imperfect results left diagnosis and therapy

equally empirical as the follicular catarrh was closely associated with trachoma though entirely distinct.

The present day treatment was always commenced by the prophylactic precaution of preventing transmission, viz., washing well with antiseptic fluids, to which too much importance cannot be attached. The treatment may properly be divided into three categories: (1) medicaments, (2) mechanical, (3) operative medicines. From early times silver, copper, and belladonna have been the sovereign drugs which are replaced by sublimate, 1 in 20,000 to 1 in 100, ichthyol, iodoform, kreolin, iodide of potassium, iodine in combination, tannin, boracic acid, quinine, antipyrin, carbolic acid, pyocetanin, petroleum, and 95 per cent. alcohol.

The mechanical treatment was extensive. Keinig's consisted in rubbing $\frac{1}{2}$ per 1,000 of a sublimate solution into the eye-lid with a piece of cotton wool. Massage has been practised with great success. The spray is often of service. The galvano-cautery is most effectual in the out-patients' department, allowing eight days' pause; this destroys all the granulations. Electrolysis is very painful, and with Johnston's instrument gruesome.

The surgical treatment surpasses all the others for variety. The first will remove all granules with the knife; another will do it by means of a metal pencil acting on each follicle; another will do it with a suitable brush; another by scarification or combined with a brush; another by excoriate with pincettes; another by syneeing and using rolling pincettes. The latter in proper hands has given good results. Kuhnt's expressor is an instrument with two plates and pincettes attached.

To remove the subsequent pannus, Wecker's jequirity method may be adopted, although stubborn cases may require the galvano-cautery.

In the discussion that followed, Mittler asked the usual practice adopted in Hungary?

Adler said there were two hospitals for such cases in Hungary under the direction of Prof. Feuer. Every case discovered is removed to hospital, and the home disinfected. No particular form of treatment is set down as a rule, but each assistant is allowed discretion.

The Operating Theatres.

ST. MARY'S HOSPITAL.

POPLITEAL ANEURYSM.—Mr. EDMUND OWEN operated on a case of popliteal aneurysm in a young man, a cabman. Mr. Owen remarked that it had probably been started by some severe strain upon the artery as the man was dragging his cab out of the coach-house. The aneurysm was sacculated, and he said he proposed to tie the popliteal artery in the upper part of the space; but on proceeding to do this there seemed to be so little promise of room between the upper part of the aneurysm and the opening in the adductor magnus, that the idea was reluctantly abandoned, and the vessel was tied at the apex of Scarpa's triangle with an aseptic silk ligature. Mr. Owen pointed out that the great advantage of tying the popliteal itself was that the risk of recurrence of pulsation in the sac was diminished, as well as that of gangrene of the foot, and that it was certainly unfortunate that the

inches of the artery in this case between the top of the popliteal space and the apex of Scarpa's triangle should have been unavailable in establishing collateral circulation.

BARKER'S OPERATION FOR TRANSVERSE FRACTURE OF THE PATELLA.—The same surgeon operated on a case of transverse fracture of the patella, the result of violent muscular contraction, the man trying to save himself from falling. The fracture had happened about five days previously, and the joint contained a considerable amount of dark blood, which was squeezed out through a small incision at the side of the patella. Mr. Owen then passed a large curved needle upwards through the ligamentum patellæ and in front of the trochlear surface of the femur and out through the quadriceps extensor. A thick silver wire was passed through the eye and the needle withdrawn. The unarmed needle was again inserted through the lower skin-wound, and being thrust up in front of the knee-cap was made to draw down the upper end of the wire. The halves of the patella were then brought close together in the loop of the wire and were so fixed by twisting up the wire and cutting off the ends. Mr. Owen described the operation he had performed as Barker's method, and said that he personally had, after considerable experience of it, every reason to speak well of it.

INGUINAL COLOTOMY.—The same surgeon performed an inguinal colotomy on an oldish man with advanced carcinoma of the rectum. The man had been examined under an anæsthetic by the class in the previous week, when it was thought that the malignant growth was too extended and too firmly fixed for the patient to be subjected to Kraske's operation. Mr. Owen specially pointed out that it was not necessary to bring up the peritoneum and stitch it to the skin, so as to line the wound with it; that the serous coat of the sigmoid flexure was as well able to fix itself by plastic exudation to the cut surfaces of the abdominal muscles and skin as to an opposed peritoneal surface. As there was no distension of the bowel, it was decided to delay opening it for several days, until the knuckle of intestine had become securely fixed in its new position.

KING'S COLLEGE HOSPITAL.

PYLOROPLASTY.—Mr. A. CARLESS operated on a girl, æt. 22, who had been suffering for some years from gastric symptoms suggestive of ulcer. Two years back he had opened the abdomen, explored the stomach both from without and within, and had found nothing amiss, although as the result of the operation the symptoms of gastric irritability disappeared. The improvement was maintained for ten months, but six months ago she began to suffer once more from the old troubles. Four months before the present operation she had been admitted to hospital for two weeks, but in spite of careful dieting she remained unimproved. She then went out and continued since then much in the same condition, being able to retain bread and milk, and Benger's food sometimes, but nothing more solid. On re-admission she was very thin; there was no tenderness in the epigastrium, although she complained of pain in that region after taking food. An incision was made partly to the right of the middle line and parallel to the scar of the former incision which had healed perfectly and had left no sign of hernial protrusion. On opening the peritoneum it was at once seen that there were

no adhesions connected with the stomach, and, in fact, the site of the former incision into the viscus was a little doubtful. A longitudinal incision was made into the organ about two inches from the pylorus and midway between the greater and lesser curvatures. On introducing the finger it was at once evident that the pylorus was contracted, the opening just admitting the tip of the index finger although on pressure it could be passed through the contraction. The stenosis was very limited in its extent, and Mr. Carless, therefore, proceeded to perform pyloroplasty, dividing the stricture in a longitudinal axis and stitching the wound up transversely. A double row of sutures was used, one for the mucous membrane and one for the serous and muscular coats. The first wound in the stomach was closed in a similar manner and the abdominal incision brought together with buried silk stitches after the peritoneal cavity had been filled as full as possible with warm sterilised salt solution. Mr. Carless stated that this was a typical case in which to perform pyloroplasty, the absence of adhesions, and the limited extent of the stenosis were the essential indications for such a proceeding. The operation, he said, is devised with the idea of increasing the lumen of the pyloric orifice and has been found to fulfil the expectations formed of it most admirably, the food being subsequently able to escape from the stomach without obstruction. The risk associated with the operation is very slight. Mr. Carless also drew attention to the importance of endeavouring to prevent the formation of adhesions after such an operation, and said that it was partly for this purpose that he had filled the abdomen with salt solution before closing it; a second object that is attained by this procedure, he added, is the diminution of shock, partly by the effect of the warm lotion on the sympathetic centres, partly by the rapid absorption of the fluid into the circulation. Too little attention had been in the past, he thought, directed to the prevention of the formation of adhesions after laparotomy, and consequently obstructions and strangulation by bands were only too common sequelæ. Raw surfaces uncovered by peritoneum must not be left, and surgeons and gynecologists, he pointed out, must learn to cover up all such wounds in some way or other, possibly by omental grafts, if they desired to protect their patients from the above-mentioned untoward consequences.

Society for Relief of Widows and Orphans of Medical Men.

At the quarterly court of this society, held on January 10th, Mr. Christopher Heath, V.P., in the chair, two new members were elected, and the death of Sir James Paget, president, and Mr. Gimson, a director, reported. Mr. Christopher Heath, from the chair, proposed the following resolution:—"The quarterly court of directors of the Society for Relief of Widows and Orphans of Medical Men desires to record its great regret at the death of Sir James Paget, Bart., the president of the society, who has for many years taken the greatest interest in the society's welfare and until recently has regularly taken the chair at the meetings of the court." There were fresh applications for grants, and the death of a widow was announced who had received since January, 1875, £1,333 10s. from the funds. It was resolved that £1,205 10s. be distributed among the 48 widows, 11 orphans, and the 6 recipients from the Copeland Fund. The Christmas present, £531, had been given on December 18th. The expenses of the quarter amounted to £74 14s. 6d. The nomination of a president was postponed to the April court.

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“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, JANUARY 31, 1900.

**WORKMEN'S COMPENSATION AD
ABSURDUM.**

THE principle that grants compensation to workmen injured in the course of their employment is recognised almost universally as just and beneficent. It has been adopted by the legislature and reduced to concrete form in a recent Act that marks a considerable step in the adjustment of the complex and often conflicting interests existing between capital and labour. That legislation on the question is still imperfect must be admitted by all who agree with the justice of the main proposition that a workman injured by circumstances arising directly out of his occupation is entitled to compensation from his employer. The working of an Act, however, is the only satisfactory way of finding out its imperfections, and we venture to say that the decision in a case tried within the last few weeks under the Employers' Liability Act affords a startling and even from some points of view illogical application of that particular law. Briefly stated, the facts of the case were that a collier somewhere in the North of England, scratched his hand when at work, and subsequently suffered from a septic wound, which was followed in turn by chronic septicæmia. There appears to have been no contention that the original injury was anything more serious than a superficial abrasion, such as must occur every day in the week in every factory and coal pit throughout the length and breadth of the United Kingdom. The workman brought an action against the employer, and obtained heavy damages. This decision is of the utmost importance to the future of the Compensation Acts, and we trust that there will be some appeal so as to raise the question of its validity. The main objection to the verdict that will suggest itself at once to the medical mind

is that the septicæmic condition was merely a remote and accidental complication of the accident, a septic state not essentially connected with the workman's occupation. If a scratch were to be the invariable antecedent either to blood poisoning, or to an action for compensation, then the employment of labour by capital would be seriously hampered in many industrial occupations. There is no employment conceivable in which the servant would not be exposed at some time or other to the risk of an abrasion of the skin, such as a scratch by a pin or a splinter of wood. Every such wound of the cutaneous surface, however trifling in itself, is liable to inoculation at the time or to subsequent invasion by the micro-organisms that give rise to various septic conditions of the system. Therefore, every employment is liable to give rise to septic blood conditions owing to trifling scratches incurred by workmen in the course of their occupation. Fortunately, such serious results from such trifling antecedents are rare, and in that rarity lies the key to the situation. As every medical man knows, these general septic invasions of the system following surface wounds are nearly always confined to persons who are broken down in constitution and unhealthy from various causes. In the case above alluded to the employers have most likely been called upon to pay heavy damages the demand for which would never have arisen had the plaintiff been endowed with tolerably sound bodily health, whereby he would have been enabled to resist the microbial invasion of his skin. From the decision of the judge it follows that employers must be prepared to accept risks not only as regards accidents arising out of the nature of their trade or calling but other and more remote results, such as septicæmia following trivial injuries not essential to their particular trade or calling and, moreover, entirely dependent on the bodily state of health of any workman who may be injured in that way. It may be well to recall the fact that in insurance cases remote blood poisoning is held sufficient ground for a claim. At the same time such a principle applied to vaccination would make a vaccinator responsible for septic invasion of a wound weeks after the operation. It seems to us that the chain of reasoning is conceivably open to question in a Court of Appeal. Whether that higher jurisdiction would go so far as to reverse the judgment to which we have called attention is another matter. Were domestic servants dealt with under the Employers' Liability Act, as they sooner or later will probably be included, an endless crop of litigation would be raised in the way of whitlows and “housemaid's knees,” both of which injuries may be fairly described as arising directly out of the nature of the employment. Going back to the broader aspects of the matter it is interesting to speculate upon what evidence the Court arrived at its decision in the septicæmic case. With every sympathy for the circumstances of the workman it is impossible to shut one's eyes to the fact that the employer also has his rights and immunities. To interpret the Liability Acts so as to exact damages from an employer on account of septicæmia following a scratched finger tends, we

repeat, to reduce the whole special legislation concerned more or less to an *ad absurdum* phase. By allowing the pendulum to swing too far in favour of the workman his cause may be permanently damaged. It is to be hoped, therefore, that, in the interests both of capital and labour, an appeal will be lodged forthwith in this important case. If that desirable course be not pursued then we would urge some member of Parliament to lose no time in bringing the matter before the House of Commons. Meantime, it would be well for all employers of labour, and for all journals interested in trade questions to inform themselves of the medical aspects of the matter in a more thorough and detailed fashion than has been possible within the limits of the present article.

INTESTINAL SURGERY.

NOT so many years ago the surgery of the intestines was one of the least promising departments of abdominal work, but although it still presents technical difficulties peculiarly its own we are in a fair way to see these overcome, at any rate in great measure. A few years ago the introduction of Murphy's button and Mayo Robson's bobbin was greeted with a chorus of welcome by surgeons who hoped to find in these undoubtedly ingenious contrivances a means of obviating certain technical difficulties, but subsequent experience has steadily discredited their use and skilled opinion is slowly but surely veering round in favour of direct suture by improved methods. This is hardly the place for us to dilate upon the drawbacks attending the use of these mechanical contrivances; suffice it to say that surgical opinion, as represented by speakers at the various medical societies appears to be adverse to their use except in very special circumstances. There is one condition of success in cases of injury of the intestine which, we fear, must always obtain, viz., the obligation of dealing with them within a short time of the receipt of the injury. That obligation is inherent to the anatomical circumstances, and must always militate against a great increase in the proportion of successful interventions. Surgeons have learned that the removal of comparatively large portions of intestine is not a matter *per se* of much importance while it is all important to make sure that the parts sutured shall be healthy and uninjured. The great bugbear of the surgeon in dealing with wounded intestine is the risk of the continuance of the symptoms after operation in consequence of temporary paralysis of the intestine resulting from distension. This, indeed, is one of the grave problems with which he is still confronted. Puncture of the distended intestine by the aid of a small trocar has not given encouraging results, although in the hands of veterinary surgeons it is reported to be commonly employed without an undue proportion of untoward results. Possibly, this immunity from disaster, if authentic, may be due to the fact that the procedure is had recourse to in animals which are suffering solely from distension, obviously a very different state of things

from that of the patient who is the victim of strangulated hernia, or whose intestines have been severely contused by a passing cab. However that may be, surgeons are still on the look-out for a means of emptying the intestines without entailing additional risk to the patient. It may turn out that resection of the damaged intestine, if not too extensive, is the only way out of the difficulty if only by reason of the fact that, as has been shown, the damaged intestinal wall allows the passage of the, when out of bounds, lethal coli bacillus against which it is scarcely possible to guard. There is one detail of importance which has been brought to the front in recent debates, viz., the desirability, or otherwise, of giving opium and morphia in these cases. Of late years it has been the fashion to decry their use on the ground that they mask the symptoms, and that they enhance the paresis of the intestine. Now it is open to question whether it is not a positive advantage to quiet the peristaltic movements of the injured gut for a time, if only to secure the physiological rest of which it stands in need. The masking of the symptoms is only of importance, while the diagnosis is uncertain but once this has been established there does not seem to be any valid reason for withholding the relief of suffering and shock which opium and its derivatives are capable of affording. We are glad to see that several surgeons have raised a protest against the indiscriminate refusal to sanction their use, and we may hope ere long to be favoured with a code of rules as to when these drugs may be given with advantage. One curious feature which merits passing notice is the curious difference in the degree of shock and pain exhibited by the victims of severe intestinal injury. In some, possibly in most instances, pain and shock are prominent symptoms, but there are plenty of instances on record in which grave wounds of the intestine, as indeed of other viscera, have not been followed by what the surgeon would consider adequate symptoms. This is a point to bear in mind in considering the propriety of performing an exploratory operation as a matter of routine. If the surgeon relies too much on these indications of injury he will find, in a certain proportion of cases, that life has been sacrificed for want of timely intervention. If he adopt the routine method of exploration on the other hand he will discover that his intervention was unnecessary. On the whole, however, a safe plan is to explore in every case seen within a short time of the injury. In respect of the cases seen later on the absence of grave symptoms may be taken to indicate that no serious injury of contained viscera has been inflicted.

INFLUENZA AND THE THERMOGENETIC CENTRE IN THE BASE OF THE BRAIN.

A NUMBER of the cases observed during the present influenza epidemic have exhibited no further symptoms than those of high temperature, unaccompanied by headache, arthritic pains, or any signs of catarrh of other organs. The attacks of pyrexia were generally of very sudden onset, and rapid rise of the

body temperature, and were either single or relapsing. In one case known to us in a physician 106 degs. was reached in a few hours; about double the time taken in the rise sufficing to bring the thermometer down to the normal again. In another instance, although the patient was kept in bed throughout, eighteen hours, almost precisely, elapsed between the onset of the pyrexia, three hours seeing the temperature rise to 104 degs. or 105 degs., then for nine or ten hours violent sweating and a fall to normal, at which it remained until the eighteenth hour saw it rise again. These paroxysms were unaccompanied by any other symptoms save restlessness while the temperature was rising, or by sweating as it fell. The appetite was good, the breathing quiet, the pulse no quicker than the rise in temperature called for. In this case quinine proved a specific; alkalies, antipyrin *et omne hoc genus* failing. As a rule, quinine has little effect on influenzal attacks, although useful beforehand as a preventive; in fact, it seems that where catarrhal processes have been induced by the poison it fails to benefit. It is difficult to understand how the *materies morbi* can be present in such strength as to cause intense derangement of the thermotaxic mechanism without affecting other organs of the body, and apparently other parts of the central nervous system. The influenzal poison certainly picks out the weakest part in each organism but when it confines itself to the temperature centres (and to do this a supply of bacilli and toxin must be present in the circulating fluids), it closely resembles ague, the more closely in that under such circumstances it yields to the action of quinine. The organism of influenza, therefore, would seem to be more catholic in its tastes than that of malaria, finding congenial sites in various tissues in which to set up changes, which vary with the parts affected, and result in inflammations, mild or intense; disorder of function, up to apparent insane actions on the part of individual nerve centres. When the result is pyrexia simply and is only during one attack, antipyrin, &c., suffices; when periodic, quinine arrests the process: when complicated with inflammatory action, these and other remedies in suitable combination are called for. There is no sense in laying down, anyhow, as to what one drug or method is *the* way to treat influenzal attacks; as the nature of the seizures varies so profoundly, so must our treatment. The only general law which may be possibly invariably true is, stimulate and feed as much as may be.

Notes on Current Topics.

Street Mud in Winter.

THE part played by mud in the hidden and various ways of disease-production will doubtless be one day laid bare by some curious apostle of science. Meanwhile there are certain points about mud that are clear to the man in the street. Its distribution by the splash of passing vehicles covers a much wider

field than folk usually recognise. Spots of mud thus projected may often be seen adhering to house-fronts at a height of several feet above the top of the ground-floor windows. Dry mud, be it remembered, is on the way to become dust, to be blown hither and thither with its host of microbes good, bad, and indifferent. "The bacteriology of street mud" who will undertake that investigation, laborious, well-nigh boundless, fascinating, complexly baffling, and yet fraught with vast potentialities for the good of man. The average citizen, however, knows little and cares less for the bugbears of bacteriology; he is more concerned for the safety of his clean collar, the polish of his silk hat, the sheen of his shoes, and the untarnished splendour of his raiment beneath the splatterings of a muddy day in the City. Where the mud comes from is a mystery in the case of smooth impermeable pavements. It is certainly greatly lessened in amount when asphalt, concrete, or wooden roadways replace the time-honoured macadam. Judging from the signs of the times it seems likely that in a not distant future sanitary authorities will learn to take a deep interest in the matter of City mud in relation to the public health.

The Value of Anti-Vaccinationist Evidence.

WANT of candour is a common and conspicuous failing on the part of those of our countrymen who are inspired with the stubborn spirit of "faddism." The anti-vaccinationists are of that ilk and the history and literature of their faction abundantly illustrate the methods of suppression of facts and of fallacious reasoning dear to narrow and ill-trained minds. A certain number of newspapers pander to the follies of the anti-vaccinationist, just as they would to any other untruth or absurdity that would be likely to swell their circulation. This section of the Press paraded a recent death at Ashton-under-Lyne as that of a "Victim to Vaccination." A sober consideration of the facts, however, must convince everyone that vaccination had no more to do with the death than an ordinary scratch or pin-prick. A child, five months old, was vaccinated with the glycerinated calf lymph of the Local Government Board on December 19th. The operation was conducted by the public vaccinator, who afterwards applied an antiseptic dressing. On January 3rd, erysipelas appeared, and the child died shortly afterwards. The facts that disconnect the erysipelas from the vaccination are: 1, the use of glycerinated calf-lymph, which is sterile of all but vaccine organisms; 2, the antiseptic precautions taken by the vaccinator; 3, the interval of fifteen days between the inoculation and the appearance of the erysipelas, pointing to a late inoculation of the wound, probably by neglect and carelessness of the parents. The jury recognised the true state of affairs in their verdict which was to the effect that the child had died from exhaustion, consequent upon erysipelas, supervening upon vaccination, but how the erysipelas was contracted there was no evidence to show. The newspapers have made their own evidence.

Materia Medica on a Large Scale.

THE central administration of the hospitals of Paris is a large customer in the drug market, as might be imagined, but the figures in this year's estimates are nevertheless calculated to cause some astonishment. By way of purgatives, the annual consumption of castor oil reaches 1,900 kilogrammes, with 3,000 kilogrammes of Epsom salts, 1,600 of sulphate of soda, and 60 of senna leaves. It takes 30 kilogrammes of ipecacuanha root to get the patients to expectorate with ease, but 10 kilogrammes of male fern suffice to rid them of their intestinal parasites. Sedatives obtain a large share of patronage, bromide of potassium running to 1,200 kilogrammes, of sodium 150, of ammonium 60, and of strontium 10, along with a kilogramme of bromide of gold. Sulphurous baths are in great favour in France, but even so 40 tons of liver of sulphur is a tall order. Quinine has for years stood at four tons, and the number of empty cachets, a mode of administering medicaments greatly appreciated by French patients who are refractory to nauseous mixtures, reached the gigantic total of 800,000. The consumption of peptone rose last year from 80 to 100 kilogrammes, but pepsin fell from 40 to 10 kilogrammes, which looks as if that ferment had seen its best days. The consumption of kola also fell (250 to 200 kilogrammes), but this may be due in part to the more restricted use of so-called medicated wines, into the composition of which kola enters for a very large part. Among miscellaneous details we note 40 tons of liquorice and 1,600 kilogrammes of cherry-stalks. In the matter of cod-liver oil 16 tons ought to go a long way, and as much may be said of the 60 tons of glycerine and the 16 tons of vaseline. By way of conclusion we have 12 tons of boracic acid, 1,600 kilogrammes of corrosive sublimate, close upon 10 tons of carbolic acid, half a ton of permanganate of potassium and 24,000 litres of camphorated alcohol. A detail not without interest is an increase in the quantity of chloroform consumed, from 1,200 to 1,600 kilogrammes, while ether remains stationary at 1,400 and cocaine at 12 kilogrammes. Not the least interesting feature of the materia medica budget is the uniformity which characterises the demand year by year. Evidently if there be such a thing as fashion in medicine it stops short at the threshold of the hospitals.

The Housing of the Poor Problem.

THE urgency of the question of the housing of the poor in our great cities is shown by the rapid phases in which the matter has been presented to the public. Local authorities throughout the kingdom have been aroused and many schemes adopted, not a few of them of a costly and complicated description. The ever-present difficulty is to rehouse near their former abode the population, displaced by the demolition of unhealthy areas, and by other public improvements. The latest departure of the London County Council involves an expenditure of about half-a-million. They have bought thirty-eight acres of land at Tooting for

£45,000. Upon the site thus acquired they propose to erect workmen's cottages under Part III. of the Housing of the Working Classes Act. In this way accommodation would be provided for 12,000 persons. One of the members of the Council pointed out that nine months had been consumed in buying a site to house 12,000 persons, but during that time the population of London had increased by 30,000. Before the houses were finished the population would have increased by 160,000. Fortunately, a fair proportion of the enormous annual addition does not belong to the class of society affected by the housing problem. Within the next fifteen or twenty years it seems likely that enormous sums will be expended under the Act in various parts of the country. The burden will fall on the already heavily taxed ratepayers, who will possibly be left to ponder to some purpose the why and wherefore of the exemption of ground landlords from the payment of rates.

A Plague Laboratory.

THE St. Petersburg Institute of Experimental Medicine has just completed the construction of a laboratory for the study of plague and the preparation of anti-plague serum which is probably unique of its kind. The building is situated within the fortress of Cronstadt, and is surrounded by water on all sides so that it is completely isolated. It is provided with stabling for twelve horses, and apartments for the staff and the assistants; there is even an isolation ward for the reception of any of the employes who may be unfortunate enough to contract the disease. It is self-lighted by electricity and communication with the mainland is secured by a small steam launch. No doubt the lamentable catastrophe at Vienna which startled the scientific world a few months since suggested these elaborate precautions. Such a laboratory is indeed as potentially dangerous in its way as a powder magazine, possibly even more so, because there still exists the theoretical risk of the conveyance of infection. It would, however, be difficult to suggest any further precaution short of condemning the staff to perpetual banishment on their island.

The Apothecaries' Society and the General Medical Council.

THE announcement that Sir Hugh R. Beevor, Bart., has been appointed representative of the Apothecaries' Society of London on the General Medical Council entails the disappearance from that body of a member, Mr. Brudenell Carter, whose individuality had of late been felt to be somewhat burdensome. Mr. Carter accepted the representation at a time when the Society required the services of an experienced and unflinching advocate, and he unquestionably fulfilled his task with much vigour and skill. Having steered the Society through the shoals and having assisted in securing it a fresh lease of existence under peculiarly favourable circumstances, Mr. Carter continued to represent that corporation in a way which was certainly not to the taste of the profession nor apparently to

that of his constituent body. Past master in sarcasm and invective, his caustic oratory was wasted when devoted to the discussion of the arid details of professional education, and was out of place when questions of medical policy were being debated. As member of the Penal Cases Committee, Mr. Carter succeeded, quite unnecessarily, in arousing deep-seated hostility all round, but whether this was the result of negligence or of indifference we are left in doubt. It must be admitted, on the other hand, that Mr. Carter not unfrequently imported into the debates an animation which is usually conspicuous by its absence, but we are not sure that the result was always to promote the urbanity of debate which ought always to characterise the proceedings of so august a body as the General Medical Council. Mr. Carter's career on the Council recalls to one's mind the adage that "though 'tis good to have a giant's strength, it is not good to use it as a giant."

Clergymen as Sanitarians.

THE Church Sanitary Association has done well to turn its attention to a matter which is deserving of much consideration, namely, that of inducing the clergy throughout the country to become the advocates of sanitation among their parishioners. Next to the medical practitioner the clergyman of the parish has generally the most influence in advising the poor to do that which is good in their own interests, and inasmuch as a great deal of what we regard as unhygienic habits arises from mere ignorance, it is obvious that the enlightenment of the poor upon such matters could readily be undertaken by the clergy were they willing to do so. For example, in many poor rural parishes much could be done by tactical advice by the clergy in the promotion of the observance of sanitary laws among their poor parishioners. The penalty of offending against hygienic and sanitary laws is generally exacted either in the form of sickness or death, and not only the individual but oftentimes, no doubt, the community would gain in cases where timely advice on sanitary matters given by the clergy were acted upon. The clergy might well devote some of their spare time to the administration of useful knowledge of this kind within their respective parishes.

Neglect of Dentistry in Medical Education.

IN our issue of January 3rd we commented upon the undeniable fact that, while the student is laden down with the minutiae of diseases which he will probably never see in a lifetime and is harried at his examinations on such subjects, he is sent out into practice without adequate teaching or testing on the subjects with which he has to deal, all day and every day, from the moment he enters into general practice. As illustrations, we instanced the passing of a catheter, the application of a leech, and the extraction of a tooth as procedures which are the very elements of a student's profession, but without a knowledge of which he may go into practice. The journal of the British Dental Association, in an endeavour to controvert this statement, affords us valuable

evidence of its accuracy. It says that at two London general hospitals (out of twelve to which schools are attached) "the student is able to receive the most careful instruction in such details as are likely to be of importance in general practice," and, furthermore, it believes that, "in one of these two hospitals each house surgeon acts, during his three months, as assistant to the dental surgeon." If the instruction thus indicated is, confessedly, all that London medical students can obtain outside of a special hospital, we apprehend that our case is proved. But we may remind our contemporary that, in medico educational matters, it is not enough to inform the student that he "is able" to obtain information in some particular subject unless he is made to produce such information at his examination, a requirement which is never thought of, yet we must assume that his inability to get a tooth out of its socket is amply compensated when he comes to earn his professional living, by his erudition in the domains of psychology, forensic medicine, and other such business-like and practical subjects.

The Case Against Hospital Isolation in Scarlet Fever.

WE have been favoured with a pamphlet with this title from the pen of Mr. Edward Dean Marriott, of Nottingham, which we have perused with more curiosity than interest. Compulsory isolation unquestionably has its drawbacks, and we had looked forward to an interesting, if unconvincing, disquisition in which, as is the manner of disquisitionists, the disadvantages would be heartfully marshalled in such a way as to throw a new light on this modern departure in municipal hygiene. Instead of that, we have a somewhat hysterical protest against compulsory segregation, couched in language which may be described as odd, in which serious argument is conspicuous by its absence. It would have been much more to the point if, instead of accusing the sanitary authorities of "fooling around" and "smashing up" the health of sundry of his little patients, the author had set himself the task of deducing such lessons as might legitimately be drawn from the admitted failure of the isolation system to stamp out this particular disease. The author sees in the steadily-increasing spread of scarlet fever a *consequence* of compulsory isolation in hospital, whereas most people capable of forming a dispassionate opinion would consider that the increase is in spite, and not on account, of this preventive measure. Fortunately, the greater incidence of the disease has been associated with a marked diminution in the proportional mortality, but the problem of providing accommodation for the huge number of cases must, for years to come, tax the resources of municipal authorities all over the country. Moreover, the author propounds no alternative means of dealing with these cases. He accuses practitioners of deliberately abstaining from notifying any cases after the first in a given household, on what grounds we know not. Are we, however, to understand him to advocate the abandonment of hospital isolation without any scheme to take its place? The

pamphlet appears to have been written solely for the purpose of influencing local electioneering politics, but we cannot imagine that the author's slipshod effusion will have the desired effect; indeed, local authorities, after all, have but a limited discretion in such matters.

The Prevalence of Zymotic Disease in Birmingham.

A LARGE amount of zymotic disease is at present prevalent in Birmingham. While typhoid fever and influenza are claiming their victims among the adult population, measles and whooping-cough are largely attacking the children of the town. According to the returns furnished to the medical officer of health by the chief school attendance officer during last week 70 fresh cases of whooping-cough and 187 of measles occurred among the children attending the board schools in the city. The effect so far of the prevalence of these diseases has been to reduce the attendances of the children to the extent of 2,000, thus causing a very serious interruption to the work of the schools. In this connection some discussion has arisen as to whether pertussis is or is not contagious. But there can be no question that it is a disease which is propagated by contagion. Infectious particles, no doubt, are thrown off by the cough and are conveyed to the air passages of other children, where they remain and multiply, thus causing the disease to spread together with the abundant reproduction of infectious material. Under all circumstances, therefore, wherever possible, isolation should be resorted to in order to prevent the dissemination of the disease. Although the board schools in Birmingham have not been closed, the health authorities have issued broadcast circulars giving directions to the parents and townspeople generally as to the best methods of preventing the spread of the diseases. This measure has, no doubt, proved useful, nevertheless it is evident that if the epidemics increase, a wiser plan would be to close the schools entirely.

The West London Post-Graduate College.

THE success of the West London Post-Graduate College is proved by the fact that although post-graduate teaching has only been carried on during the past three years no fewer than one hundred and sixty members of the profession, hailing from all parts of the world, have taken part in the courses. Moreover, we gather from a summary of the work of the college contributed to the current number of the *West London Medical Journal* by the Dean that there are now forty-two practitioners attending the present course of lectures and demonstrations. All this undeniably goes to show that the organisation of this undertaking has fulfilled the requirements of those in search of post-graduate tuition. It must be apparent to every one, that in this connection, access to a hospital, with the facilities for seeing the practice thereof, is an absolute *sine qua non* for the members of a post-graduate course. The complaint is often made by such that their requirements are not met by

a series of so-called set lectures. Lectures, as such, are reminiscent of early student days, and are not helpful where practical experience is needed. Hence there is little reason for doubting in part at least the success of post-graduate teaching is due in this instance to the advantages arising from the West London Hospital being included in the scheme, by which abundant opportunities are afforded for seeing hospital practice, and of making use of the clinical material provided by a large general hospital. We gather, also, that only qualified men are admitted to the post-graduate college, an arrangement which also has its advantages from a post-graduate standpoint.

A Libellous Certificate.

THE risks attending the certification of lunatics are serious enough under any circumstances to render the prudent practitioner circumspect in dealing with them. When a medical man goes out of his way to court disaster he is entitled to no sympathy, especially when the circumstances are such as tend to bring the exercise of this very important function into contempt. Mr. T. Anderson, who practises in the north of London, appears to have had differences of opinion with his milkman, and the latter, it is alleged, cherished hostile sentiments in regard to him. In what we may describe—mildly—as an unguarded moment, Mr. Anderson, availing himself of the facilities for literary composition afforded by a friendly public house, wrote a certificate to the effect that the milkman in question was a dangerous lunatic. He was so pleased with his production that he showed it to the barmaid, possibly to see if there were any mistakes in spelling. He ultimately left the document with the relieving officer, coupled with a hint that it would be well to secure the alleged dangerous lunatic. The medical officer of the union and the assistant divisional surgeon, having examined the subject of the certificate, both declared him free from any suspicion of mental aberration, and an action was tried last week in which the defamed milkman claimed damages for libel, with the result that Mr. Anderson was mulcted in £10 damages, a very moderate sum taking all the circumstances into consideration. A medical man who writes such a certificate in a public house in order to retaliate on a milkman whom he dislikes and then hands it round for inspection, cannot complain if the sequel is somewhat unpalatable. On the whole he has escaped pretty lightly, for some juries would doubtless have taken a much more serious view of the act of which he stands condemned.

The Need for Further Medical Assistance in South Africa.

ONE of the consulting surgeons at the front in South Africa has sent home word that even now the medical department is short-handed and that more surgeons are needed. The battle of Colenso is an instance in point. The great proportion of wounded which resulted from this engagement was more than the medical staff could effectually deal with, and many hours of continuous operating seems to have

been the lot of those who were present to attend to the wounded. Despite, however, the inexpedient strain to which, from lack of help they were subjected, the officers of the medical department are reported to have done their work excellently. But in view of the demand for further help the Government should lose no time in sending out more surgeons.

The Metropolitan Hospital Saturday Fund.

THE Board of Delegates of this Fund met on Saturday last to decide on the distribution of the awards for 1899, when it was reported that the gross receipts for the financial year ending the 8th inst. amounted to £20,023 5s. 3d. This income, mainly derived from the systematic workshop collection, was fully equal to the average, the cessation of the street collection and the various funds in relief of the sufferers by the war having had no adverse influence upon the contributions. It was decided to award, in respect of 1899, £17,013 13s. 8d., as against £17,029 17s. 5d. distributed for 1898. The latest awards made numbered 175, thus made up:—28 general hospitals, £6,367; eight cottage hospitals, £180; 60 special hospitals, £4,989 1s.; 31 dispensaries, £851 4s.; 20 convalescent homes, £1,688; 27 miscellaneous organisations (including ambulance, distribution, and surgical appliance committees, also institutions for gratuitous nursing of the sick poor in their own homes), £2,938 8s. 8d.; total, £17,013 13s. 8d. The principal awards were as under:—General hospitals: London, £883 8s.; St. Mary's, Paddington, £427; Middlesex, £404 12s.; Guy's, £401 16s.; St. George's, £338 16s.; King's College, £329; Seamen's (Greenwich), £295 8s.; Westminster, £294; North London or University College, £291 4s.; Royal Free, £285 12s.; Charing Cross, £264 12s.; West London, £204 8s.; Great Northern Central, £196; London Temperance, £183 8s.; German, £175; Metropolitan, £152 12s.; and Homœopathic, £144 4s.; Special hospitals: Brompton (chest), £427; Great Ormond Street Hospital for Sick Children, £305 4s.; National Hospital for Epilepsy, &c., £256 4s.; City of London Chest Hospital, Victoria Pk., £208 12s.; East London Hospital for Children, £203; Royal London Ophthalmic, £187 12s. The largest award given to a dispensary was that to the Western General, £58 16s. Convalescent Homes: Morley House, near Dover, £279 4s.; Metropolitan (Bexhill-on-Sea), £275; Metropolitan (Walton-on-Thames and Broadstairs), £275; St. Andrews (Folkestone), £162 8s. To the Hospital Saturday Fund Distribution Committee £1,360 was granted, and to the Fund's Surgical Appliance Committee £1,000, while £100 was awarded to the Metropolitan Provident Medical Association.

An Improved Medical Curriculum for the U.S.A.

WE are glad to chronicle the fact that our confrères in the United States are making a laudable effort to improve the curriculum of the different medical schools; and they are urging on the State authorities the desirability of a State Examination

Board where such a body does not exist. An attempt is being made to introduce a uniform standard of general education for admission to study in the various medical schools. From the *Occidental Medical Times* we learn that the John Hopkins school has set an ideal example. Harvard now follows in announcing that after June 1st, 1901, only persons having obtained degrees from recognised colleges will be admitted to study in the Harvard Medical School. Many require the equivalent of a High School education and insist upon obtaining it; others announce this requirement, but have no system of examining applicants. All the leading medical schools recognise the necessity of requiring four years for the study of medicine. Such colleges should be protected in the advance they are making by the State refusing the right to practise medicine to graduate from colleges not requiring so long a course.

St. Thomas's Hospital Surgical Home.

WE understand that some changes have been decided upon, and will shortly be carried out, in connection with the management of the Surgical Home at St. Thomas's Hospital. The present resident Medical Officer, Dr. Walter Edmunds, who has discharged the duties of the post since the Institution was started some fourteen or more years ago, will retire at the end of next month, and in his place there will be appointed a junior officer, holding the position of a house surgeon. The next change is that the "Home" will be thrown open for the reception of patients to be attended by their own medical men. From all this it would seem that the authorities have decided to work the institution upon a new policy, and to make the Home less of an appanage to the hospital. In other words, the adoption of these new arrangements will simply convert it into an ordinary nursing Home, with the advantage of having a house surgeon to look after the patients, under the direction of the attending practitioners, consultants, who may happen to be called in. It is proposed to give the junior officer a salary of £200 per annum, while Dr. Edmunds was receiving £500, thus a saving of £300 a year will be gained by the new policy about to be introduced.

The Decline of the Death-Rate.

A FALL in the weekly death-rate from 33.3 to 26.9 is welcome, and it may, perhaps, be taken as an indication that the epidemic of influenza is declining. Another explanation, however, would be that the proportion of old, weak, and ailing persons, of these who fall ready victims to the disease, is getting low. The experience of the last few years has shown that the weekly mortality follows a curiously smooth curve, rising steadily from week to week for a time and then as steadily declining. We are, therefore justified in hoping the acme is past. It is a noteworthy fact that influenza seems to flourish best during the mild winters, but the rule is not without exceptions, and it would not be safe to base any deductions as to its nature on this observation.

The Inquiry into Dublin Insanitation.

THE departmental committee which is to undertake this investigation is nearly complete. We reported last week that Dr. J. W. Moore, President of the College of Physicians, and Dr. R. L. Swan, President of the College of Surgeons, had been nominated by their respective colleges. The Irish Local Government Board will be represented by Mr. C. P. Cotton, late chief engineer to the board, but the delegate from the English board has not yet been named. The Corporation has nominated the Right Hon. Alderman Meade and Alderman Dowd but, as it was asked to nominate only one representative, and as compliance with its demand would give the Corporation a voting predominance over all other participants in the inquiry, it is not likely that more than one representative will be appointed. The Corporation, also, has urged that the evidence given before the Commission should be on oath, in which view we concur. Although we do not see that there is much to investigate save ways and means, all parties being already agreed as to the causes of Dublin insanitation, we consider that it is of the greatest importance that the verdict of the Commission shall receive the confidence of the citizens which it will probably not do if the testimony submitted to it is only verbal gossip.

The County Boroughs as Contributors to County Funds.

AN important test case was decided at Manchester last week in which the principle of the proportional liability of county boroughs to the general fund for the maintenance of lunatics was defined. Hitherto the county boroughs have paid on the rateable value of their respective areas, but under the Agricultural Act of 1896 the rates applicable to agricultural land were reduced by one-half, and it was contended that their respective contributions to the general fund should be reduced *pari passu*. This view, however, has not been endorsed by the Court of Appeal. It is now laid down that the gross rateable value is the proper basis for calculating the amount of the contribution and the reduction of the rates as applied to agricultural land does not interfere with the rateable basis. The point is obviously one of far-reaching importance, for a contrary decision would have thrown a heavy additional burden on the urban boroughs.

Mercer's Hospital, Dublin.

THE election of a surgeon to this hospital in place of Dr. Henry Moore, who has just been appointed to the City of Dublin Hospital in room of Mr. Wheeler, will not take place until the end of February. The names of candidates were to have been sent in yesterday, of whom there have been, probably, at least six. We have official knowledge, however, of only three. Mr. Harry Croly and Mr. G. B. White, already mentioned, and Mr. Burgess, formerly assistant surgeon to the Richmond Hospital, and an examiner in the Royal College of Surgeons.

Representation of Corporation on Hospital Boards.

AT the meeting of the Dublin Corporation last week it was intimated that the grant to Jervis Street Hospital would be opposed on the ground that the Governors had declined or omitted to elect any representative of the Corporation on the board. This was stated as a general principle applicable to all hospitals in future.

PERSONAL.

THE late Sir Richard Thorne-Thorne left an estate valued at £8,371 6s. 3d. including personality of the net value of £4,621 15s. 2d. —

DR. R. M. WILSON, of Duffield Road, Derby, has volunteered to accompany the local company of Imperial Yeomanry to the front. Mr. T. Aulton, veterinary surgeon, Derwent Street, will also proceed to South Africa with the detachment.

DR. JULIUS ALTHAUS has been elected an honorary member of the International Congress of Medical Electrology and Radiology, which will be held as part of the International Medical Congress, in Paris, in July next, and will deliver an address on the general indications of galvanisation and faradisation.

SIR WM. THOMSON leaves this country on Saturday to take charge of Lord Iveagh's Irish Hospital for South Africa. Dr. George Stokes, of London, second surgeon; Dr. Alfred Fivel, of Waterford, assistant surgeon; and Dr. James Coleman, physician to the Richmond Hospital, will follow in a few days with the full hospital equipment.

IN addition to the foregoing members of the Surgical and Medical staff, Mr. Francis Counihan, M.B., T.C.D., will take charge of the staff of dressers, having as his assistants Mr. John Pounden, M.B., T.C.D.; Mr. Percy Stewart, Mr. John McIlwaine, Mr. Douglas Thomson, and Mr. J. Edwards. The entire cost of the Hospital will be borne by Lord Iveagh.

WE understand that Dr. George Burbidge White, of Dublin, has presented to the Irish Field Hospital the complete apparatus of his double-chamber steam steriliser. He claims for it the advantages over every other such apparatus of portability and readiness for use at any moment, attributes of obviously great value in military service.

THE candidates for the seat vacant by the elevation of Sir John Lubbock as Parliamentary representative of the University of London, are Sir Michael Foster, Dr. Collins and Mr. Busk, the two first-named are members of our profession; all are well-known public men, and as a correspondent puts it, "distinguished in learning, science or literature." The choice is thereby rendered all the more difficult.

Scotland.

[FROM OUR OWN CORRESPONDENT.]

EDINBURGH ROYAL INFIRMARY.

THE Memorial Pavilion of the Queen's Diamond Jubilee is nearing completion, the builder's part of it being finished; and the managers of the Infirmary are commencing proceedings towards the erection of the two other blocks included in the original extension plan.

Warrants have just been granted giving them leave to build a new ear and throat position, and one for eye diseases on the ground to the north of the Jubilee gynaecological block, where the old disused laundry buildings stand.

The ear and throat pavilion consists of an administrative portion in the centre, three storeys high, with wings two storeys in height. The ground floor provides accommodation for the out-patients, with separate entrance, and consists of large waiting-room, examination-room, operating room, and large operating theatre. The upper floor consists of two wards for eight patients each and two small wards for two patients each; ward kitchen, doctor's and nurses' room, and the usual lavatory accommodation, with passenger and food lifts from top to bottom. The second or attic floor, over the administrative portion, consists of nurses' and servants' bed-rooms, bath-rooms, &c. The ophthalmological pavilion also consists of a central administrative portion, which is four storeys high, the wings at either side three storeys in height. The ground floor provides for the out-patients, with a separate entrance, and consists of large entrance hall and waiting-rooms for male and female patients, two large rooms for out-patients (clinic), dark-room, retiring-room, laboratory and surgeons' room. The two upper floors consist of two wards of ten beds each, dining-rooms for male and female patients, ward kitchens, nurses' rooms, operating-room, and the necessary lavatory accommodation, with passenger and food lifts. The attic floor of the central administrative portion contains bed-rooms and bath-rooms for nurses and servants. All the floors are fireproof, and the sanitary arrangements are of the latest and best description. The warming of the whole buildings will be done by steam pipes and radiators, and the exhaust ventilation by means of electric fans. Electric light is to be installed throughout. The new pavilions are connected with each other and also with the main medical and surgical hospitals by a light corridor of glass and wood, and the food for the patients will be conveyed to the new wards along this corridor from the main kitchen, which is at present being largely extended to meet the prospective increase of patients. The total cost will reach to about £45,000.

As a set-off against this expenditure the managers were the lucky recipients last week of the magnificent sum of £40,000, a donation given by Mr. Aitken, of Edinburgh, in memory of his wife. When the three new blocks are occupied, the number of beds available for patients in the Royal Infirmary and the affiliated convalescent house will, we believe, exceed those in every other hospital in the kingdom.

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

THE SURGEONCY TO THE QUEEN'S COUNTY INFIRMARY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your article on the above subject in last week's MEDICAL PRESS AND CIRCULAR is so inaccurate and misleading in many particulars that I venture to ask you in the interests of truth to place a more correct statement of the facts of the case before your readers. In the first place the name of the gentleman elected to the office on the 10th inst. is Niel Blaney and not Arthur Joseph McCauley Blaney, and he qualified in 1898 as M.B. of the Royal University, and not in 1893 as M.D. as you imagined. You further state that the surgeoncy was "occupied up to the spring of 1898 by Dr. William Jacob." Whereas the date of his election to the position was May 20th, 1898, whilst the Local Government Bill was passing through Parliament, and he remained in occupation until September 17th, 1899, when he was dismissed by the newly-constituted joint committee of management after his refusal to accept the option of resigning the dispensary appointment which he also

held. The "dominant party in the council" were not guided by any such motives as you attribute to them in the matter, and not a single one of the members of the committee appointed was ever asked to support my candidature for the position until after the vacancy was declared and advertised. As to my qualifications for it, even those who voted against me were obliged to admit that the Fellowship diploma of the Royal College of Surgeons obtained by me in 1887, after an honourable examination in the full curriculum and eighteen years' experience in the practice of my profession in this county, afforded more considerable guarantees for the efficient discharge of the duties of the surgeoncy than either the Licentiate certificate of Dr. William Jacob or its equivalent in professional status, viz., the M.B. degree of Dr. Blaney. The fact that I am Coroner for the county was the one sole objection raised against me. My tenure of the Stradbally Dispensary would necessarily be determined immediately in case of my election to the County Infirmary as I would be bound to reside within one mile of that institution. Only four of the members appointed by the council voted against me and three of the "original governors who supported Dr. Jacob" also joined them in electing Dr. Blaney by a majority of one. These are the facts, and your information to the contrary is entirely erroneous. If Dr. Jacob succeeds in establishing his claim to the office well and good. I did not oppose or challenge his occupancy at any time on personal grounds, and I am therefore neither "hoist" nor perturbed in any way as you pleasantly fancy by what has taken place. But should he fail in the proverbial uncertainty of the law it is just possible that another issue will then be raised before the case of the surgeoncy is finally disposed of, as some of the "original governors" who voted against me are liable to disqualification and other penalties for various reasons unnecessary to mention at present.

I am, Sir, yours truly,

THOMAS HIGGINS, F.R.C.S.I.

Stradbally, Queen's County,
January 22nd, 1900.

[The only error in our previous report was in the Christian name of the new surgeon to the Infirmary and we apologise for it. The fact is that the local newspapers gave different initials, and, on referring to the *Medical Register* and the medical directories, we could find but one Dr. Blaney, to whom, therefore, we credited the appointment. It appears now that the young gentleman selected possessed the same surname and exactly the same qualifications and had occupied the same positions in the same hospital as the gentleman named by us, but he is some years younger and had not been entered on the *Medical Register* until January, 1900, too late for the most recent issue of that book. For the rest, we have only to say that Mr. Higgins and the "dominant party in the County Council" must be judged by the pronouncement of their newspaper organs, and the editorials of those organs are extant to prove that, as we have said, the dismissal of the surgeon, the canvass for Mr. Higgins, and the ultimate election of Dr. Blaney, junr., were at no time anything more or less than a politico-religious job.—Ed.]

Obituary.

DR. GRIMSHAW, C.B., REGISTRAR-GENERAL FOR IRELAND.

ALIKE unexpected and unwelcome was the death of this valuable public officer and estimable gentleman, which was announced last week as the result of influenza and pneumonia. Dr. Grimshaw was born in 1839, and was the son of a well-known dental surgeon, Dr. Wrig-

ley Grimshaw. He married in 1865, in his twenty-sixth year, Miss Thomas, daughter of the Rev. Thomas. He finished his education in Trinity College, in which he was Moderator in Experimental and Natural Science, and Briggs Exhibitioner, and carried off several honours in Medical and Natural Science. He was a Fellow and Past President of the College of Physicians, and had filled the posts of lecturer in the School of Medicine at Steeven's Hospital, of physician to that institution, and to the Cork Street Hospital, and Dublin Orthopædic Hospital, and at the time of his death he was consulting physician to these institutions. Attention was called to his aptitude in statistics while he filled the post of President of the Statistical Society of Ireland. He served on several Commissions. He published various papers and articles on statistical subjects, and as Registrar-General had charge of the Government reports and statistics of births, deaths, and marriages, agriculture, emigration, railways, crime, and banking.

It is gratifying for us to look back upon the fact that the MEDICAL PRESS was the most earnest advocate of Dr. Grimshaw's claim to the high office which he filled when many other excellent competitors were seeking the position, and to feel that, in the long series of years during which he has occupied it, his administration of his department has more than justified the confidence which the public and the Government reposed in him. During his tenure of office more than one decennial census laid heavy burthens upon his responsibility and fully tested his capacity, while his reports on agricultural statistics were of great public service, outside the medical registration which was his daily work. He was a good-natured man, but also a determined Chief of department and, we are certain that, now that he has gone, there are very few who, could, with justice complain of his official actions.

Literature.

MACPHERSON'S MENTAL AFFECTIONS. (a)

THIS book is fittingly spoken of by the author as an introduction to the study of insanity. It is so from a high standard, and consists essentially of lectures delivered during several sessions to the students attending the class of mental diseases in the Royal Colleges' School of Medicine, Edinburgh. A glance at the outlines shows at once that the author takes a broad and at the same time a deep grasp of the subject, and that, while the scheme and detail of the book may be too much for the average student and practitioner, they will appeal to those who work in the same field and be helpful in advancing a more philosophic knowledge of the subject. The classification is a departure from what we are accustomed to in English text-books, but it is on right lines, though as in the case of general paralysis, the author taking perhaps too much for granted, we are not yet prepared to subscribe to the doctrine that it is a toxic insanity due to syphilis any more than we are prepared to dispute the counter statement that in either predisposing or exciting causation we find always a toxic influence. Dr. Macpherson has evidently been inspired by foreign writers, especially of the French school. His chapters on confusional insanity are very good. Here, however, we are much struck by the elaborate differentiation rather than by the clinical fulness of some of the descriptions. The term moral insanity is still retained, and we question if this is wise, for it is a most unfortunate term from a medico-legal point of view. On the subject of impaired or arrested development the author's writings are meagre, and the study of physical stigmata is not sufficiently differentiated. The study of the feeble-minded has become a very important one. The weakest part of the book is that on treatment, and though it must be admitted that we are far from advanced in this respect, many practical hints are still possible. The book is devoid of illustrations, but the author is probably wise in not repeating what

is already stereotyped. We commend this volume to those in the higher walks of psychological study, for it contains some excellent essays.

CHARTERIS'S PRACTICE OF MEDICINE. (a)

THERE must always be a large demand for a good epitome of medicine and therapeutics, the subjects, in their full extent, being so voluminous and incapable of being dealt with in a limited space. For this reason all judicious abridgments of the subjects have been well received by the profession, and this book, among them, has sold out seven editions and is now offered in its eighth. It has been brought up to-date by its present editor, who has received the assistance of Professor Stockman and Dr. Walter Colquhoun, of Glasgow University, and we consider that their task has been completed with as much accuracy as the necessary brevity of such an epitome will allow. Appendices are attached containing suitable prescriptions, formulæ and an abundant glossary of medical terms. On the whole, we can recommend the work to the busy practitioner or student.

EDINGER'S ANATOMY OF THE CENTRAL NERVOUS SYSTEM IN MAN AND VERTEBRATES IN GENERAL. (b)

THIS translation by Dr. Winfield S. Hall and others, is from the fifth German edition. The most striking merit of the work is that it presents the comparative morphology of the central nervous system. Part I. is introductory, and, according to the author, gives the fundamental ideas accepted at the present time. This is scarcely correct, for there are still difficulties in the way of accepting the conception of the structure relations, and associate function of neuron and neurona advanced by some able observers at the present time, indeed, to use the author's own words, "we stand still in the current of changing opinions." The first chapter is a review of the history and the methods of investigation of the central nervous system from which one gathers the impression that very little has been contributed by this country—scarcely a fair impression. The second and third chapters deal with the minute structure and relations of the neuron and with physiological processes, chapters of great interest, and very instructive. The physiological part scarcely rises above the simplest physiological processes, and while having established an anatomical idea of nervous structures, we should be interested in having the author's theory as to how the activities of mentalisation are produced, we must admit that he has stopped short on the threshold with discretion. The review of the embryology and comparative anatomy of the vertebrate brain is well done. Here, as elsewhere throughout the work, the illustrations are numerous and excellent. Beginning with the amphioxus, which practically possesses only a spinal cord, he illustrates by stages upwards the brain development of vertebrates. In some of the figures here the designations have not been rendered from German to English, which is rather unfortunate. The great bulk of the work is devoted to the third part dealing with the special anatomy of the mammalian brain with especial consideration of the human brain. While much of it has been gone over by writers and students again and again, there is much of fresh interest in view of the comparative anatomy studies here introduced, and this section is correspondingly valuable. The translators have done their work satisfactorily. They have found it necessary to interfere with the text, condensing, or omitting as the case may be. In some cases the rendering has been too literal, so that clearness of meaning is lost. These, however, are rare faults; and the work as an English addition to the literature of neurology is most acceptable.

(a) "The Practice of Medicine." By the late M. Charteris, M.D., Professor of Materia Medica and Therapeutics, Glasgow University. Eighth edition. Edited by his son, F. J. Charteris, M.B., B.Ch. Crown 8vo. Pp. 655. London: A. and J. Churchill.
(b) "Anatomy of the Central Nervous System of Man and Vertebrates in General." By Ludwig Edinger, M.D. American translation. H. K. Lewis and F. A. Davis and Co. 1899.

(a) "Mental Affections." By John Macpherson, M.D., F.R.C.P.E. London: Macmillan and Co., Ltd. 1899.

NEW BOOKS AND NEW EDITIONS.

The following have been received for Review since the publication of our last monthly list:—

BAILLIÈRE, TINDALL AND COX (London).

Experiments on Animals. By Stephen Paget, F.R.C.S. With an introduction by Lord Lister. Pp. 374, price 6s.

Aids to Materia Medica. Part III. (Concluding volume). *Synthetic Products, Glandular and Serum Therapeutics.* By W. Murrell, M.D., F.R.C.P.Lond. Pp. 84, price 2s. 6d.

The Pathological Statistics of Insanity. By Francis O. Simpson, L.R.C.P., M.B.C.S. Pp. 132, price 10s. 6d.

CASSELL AND CO. (London).

A Manual of Chemistry. By Arthur P. Luff, M.D., F.R.C.P., and F. J. Page, B.Sc., F.I.C. Pp. 541, price 7s. 6d.

J. AND A. CHURCHILL (London).

The Practice of Medicine. By the late M. Charteris, M.D. Eighth Edition. Edited by F. J. Charteris, M.B., Ch.B. Pp. 655, price 10s.

H. J. GLAISHER (London).

On Granular Kidney and Physiological Albuminuria. By Samuel West, M.D.Oxon., F.R.C.P.Lond. Pp. 198.

JAMES MACLEHOSE AND SONS (Glasgow).

Glasgow Hospital Reports. Edited for the Committee by G. S. Middleton, M.A., M.D., Henry Rutherford, M.A., M.B., and W. K. Hunter, M.D., B.Sc. Vol. II., pp. 402.

MACMILLAN AND CO. LIMITED (London).

Lessons on Prescriptions and the Art of Prescribing. By the late W. H. Griffiths, Ph.D., L.R.C.P. Revised, pp. 148.

KEGAN PAUL, TRENCH, TRUBNER AND CO. (London).

A First Book in Organic Evolution. By D. Kerfoot Shute, A.B., M.D. Pp. 285, price 7s. 6d.

YOUNG J. PENTLAND (Edinburgh).

The Edinburgh Medical Journal for 1899.

THE SCIENTIFIC PRESS, LIMITED (London).

Nursing in Diseases of the Throat, Nose, and Ear. By Macleod Yearley, F.R.C.S. Pp. 113, price 2s. 6d.

SIMPKIN, MARSHALL, HAMILTON, KENT AND CO. (London).

The Retrospect of Medicine. Vol. 120. July to December, 1899. Pp. 442, price 6s. 6d.

G. STEINHEIL (2, Rue Casimir, Delavigne Paris).

La Pratique des Accouchements, Obstétrique Journalière. Par le Professeur Henri Varnier, M.D., Paris. Pp. 440, avec 387 figures. Prix 26 francs.

JOHN WRIGHT AND CO. (Bristol).

Surgical Handicraft by the late W. Pye, F.R.C.S. Revised and Edited by Bertram Roberts, M.D., B.Ch.Oxon. Fourth edition, price 10s. 6d.

Medical News.

The Corporate and Medical Reform Association, Limited.

THE annual meeting of the Association, adjourned from December 30th, 1899, was held at the Holborn Restaurant on the 17th inst., Mr. George Jackson, F.R.C.S. Eng. (Plymouth), retiring President, being in the chair. The annual report was unanimously adopted. Since the last report the membership of the Association had increased from 40 members to 316, including ten affiliated societies, in the following order of joining: New Cross, Beckenham and Penge, Gateshead, Ilford, Mid-Tyne, Hartlepool, Wool Green and District, Hull, Bradford and West Riding Medical Union, Newcastle Medical Ethical Society. The arrangements for affiliation had been found to work harmoniously; and the finances were in a position of satisfactory and increasing stability. Officers and Council were unanimously re-elected. Dr. Jas. A. Myrtle, J.P., Mayor of Harrogate, president-elect 1898-99, then took the chair as President, and delivered a brief address, graphically mentioning the rapid increase of the Association, not only in numbers, but in its influence for good in the field of medical politics; and predicting still more rapid increase in both respects in the future. Mr. George Jackson, F.R.C.S. Eng., Plymouth, was chosen president-elect, and Dr. J. Higham Hill, F.R.C.S., Bedford Square, President of Council. The annual dinner took place after the business meeting had concluded.

A Compositor's Death from Lead Poisoning.

THE adjourned inquest on the body of a lad who had died of lead poisoning was resumed at Derby last week

It transpired that the deceased worked as a compositor, but took only tea in the office. It was stated that the lead dust adhering to the type would be capable of causing toxic symptoms, and a verdict to that effect was returned. The case is interesting in that type setting is not generally credited with being a dangerous trade, nor, with ordinary precautions, do we believe it can be so described.

Death of a Veteran Practitioner.

THE death is announced of Mr. Thomas Jones Dyke, of Merthyr, at the ripe age of 94. The deceased gentleman, who was known as the "grand old man" of the district, took his L.S.A. in 1837, and was elected a Fellow of the Royal College of Surgeons of England in 1866. He retired from practice in 1894. During a long and active career, Mr. Dyke took an active part in the sanitary administration of the town, he was made a justice of the peace, and for several years held the post of high constable.

PASS LISTS.

Conjoint Examinations in Ireland by the Royal College of Physicians and Royal College of Surgeons.

Final examination.—Passes:—

- A. Passed in All Subjects: F. G. FitzGerald, H. W. Spaight.
- B. Completed the Examination: E. J. Cane, R. J. Franklin, R. H. Moffit, T. D. Sullivan.
- C. Passed in Medicine: W. J. Anglim, C. C. Meeke, P. J. McGinn.
- D. Passed in Surgery: L. A. Hare, C. C. Meeke, J. H. O'Connell.
- E. Passed in Mental Disease.—W. J. Anglim, W. S. D. Bird, C. C. Meeke, P. J. McGinn, J. H. O'Connell.
- F. Passed in Midwifery: W. J. Anglim, W. S. D. Bird, M. M. Goldfoot, N. P. Kirby, C. C. Meeke, P. J. McGinn, J. H. O'Connell, D. Power.
- G. Passed in Ophthalmology: W. J. Anglim, N. P. Kirby, J. H. O'Connell, D. Power.
- H. Passed in Forensic Medicine, &c.: C. J. D. Odeiraine, D. Power.

Royal College of Physicians of London.

At a meeting held on Friday last, January 26th, the following candidates having passed the required examinations, were admitted members of the college:—

Edwin Bramwell, M.B., M.C.Ed., Walter L. Brown, M.A., M.B., Andrew Duncan, M.B., B.S.Lond., F.R.C.S., Charles O. Hawthorne, M.D., C.M., Robert Jones, M.D., B.S.Lond., F.R.C.S. and L.R.C.P., John M. H. MacLeod, M.A.St.And., M.D., M.S. Aberd., Clive Riviere, M.B.Lond., L.R.C.P., Alfred E. Russell, M.D., B.S.Lond., L.R.C.P., Alfred W. Sikes, M.D., B.S., B.Sc.Lond., L.R.C.P., Lewis A. Smith, M.B.Lond., L.R.C.P., Ralph H. Vincent, M.B., B.S.Durh., L.R.C.P.

The following candidates having passed the required examinations, received the diploma of L.R.C.P.Lond. at this meeting:—

A. P. Ambrose, M. Arango, F. Atthill, W. E. Bamber, B. S. Bartlett, L. J. Bartlett, F. E. Barwell, W. Bastian, H. W. Bayly, F. M. Bingham, A. F. Blake, F. D. Rindly, H. P. Bradley, W. P. S. Branson, E. W. Browne, C. A. D. Bryan, E. P. Burns, J. Cameron, T. Chetwood, H. N. B. Child, J. A. Churchill, H. N. Clarke, J. M. Collins, C. M. Cooper, W. E. Cooper, G. E. Cope, C. V. Cornish, J. F. Cunningham, A. H. Davies, P. C. Douglass, H. Durrbridge, G. M. Eastment, F. G. H. Edwards, T. C. English, R. Fell, H. W. Fisher, H. B. Foster, J. E. Francis, W. C. Francis, T. Gillespie, G. Gomez, A. S. Good, N. Grace, W. St. G. Grantham-Hill, W. H. Harland, F. R. M. Heggs, E. F. Hill, E. W. Holyoak, S. P. Hopewell, R. B. Horley, E. Hudson, J. W. Hunt, J. W. Illius, O. Inchley, A. W. Izard, F. B. Jeffries, B. G. Johnson, J. E. Judson, S. J. Kerfoot, R. B. Kinloch, C. Lees, H. S. Libby, L. Lindor, P. A. Loughurst, C. T. McClure, W. A. McEry, O. Marriott, H. A. Mason, R. W. H. Meredith, L. J. P. Mordaunt, B. W. Moss, P. T. Nicholls, C. North, J. W. Nunn, H. B. Nutt, H. J. Orford, V. B. Orr, A. J. Owen, T. D. Paddock, W. H. Park, J. F. Paul, A. C. Pearson, W. E. Peck, C. M. Pennefather, S. Pern, C. A. Peters, H. G. Pinker, R. N. Salaman, J. H. Sanders, E. M. Saunders, M. Sheehan, A. E. Softly, A. B. Spencer, G. H. Spencer, E. H. B. Stanley, H. Z. Stephens, P. G. Stock, W. Sutherland, W. B. B. Taylor, C. Thackray, H. Thwaites, B. B. B. Truman, W. E. Turner, J. Valerie, D. B. Von Rosen, B. A. Walker, E. Warren, R. N. Watson, C. H. Welch, W. B. E. Williams, R. Le G. Worsley, T. P. Yates.

Diplomas in public health were granted (jointly with the Royal College of Surgeons) to the following:—

John Allison, M.D., M.S. Edin., F.R.C.S. Edin. Univ., Arthur D. Cowburn, L.R.C.P. and M.B.C.S., M.D., Hugh E. Finch, M.B., B.C.L. Oxf., Harry P. Foulerton, L.R.C.P. and M.B.C.S., Shridhar Bheekjee Gadgil, L.M. and S. Bombay, Harry W. Henshaw, L.R.C.P. and M.B.C.S., John N. Martin, L.P.C.P., M.R.C.S., William D. Murray, M.B., M.S. Glas., Ernest J. Smyth, L.R.C.P., M.R.C.S., M.D., B.S. Lond., Alfred Spitteler, M.B., C. M. Madras, David J. Thom, L.R.C.P., M.R.C.S., Robert E. G. Tilleke, L.R.C.P. Ed., L.F.P. and S. Glas., M.D. Brussels, Frank H. White, L.R.C.P., M.R.C.S., L.S.A.

Notices to Correspondents, Short Letters, &c.

✉ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

ORIGINAL PAPERS.

The receipt of the following accepted papers is hereby acknowledged with thanks; their insertion will be proceeded with at once:—"The Operative Treatment of Uterine Fibroids," By W. J. Gow, M.D., Physician Accoucheur to St. Mary's Hospital; "The Risks of Unoperated Uterine Fibromyomata," By E. Stanmore Bishop, F.R.C.S., Surgeon to Ancoats Hospital, Manchester; "On Posterior (Congenital) Luxation of the Shoulder Joint," By G. Burbridge White, M.D., F.R.C.S.; "Therapeutic Notes on the Delirium of Coffee Drinking and Antipyrine," By George Foy, M.D., F.R.C.S.I.

UNPROFESSIONAL ADVERTISING.—We referred last week to an advertisement (which appeared in a Clonmel paper) signed with the name of Mr. Redington, of the Richmond Asylum, Dublin, in which his claim to be appointed Resident Medical Superintendent to the Clonmel Asylum was put forward. We felt ourselves compelled to rebuke emphatically the publication of any such advertisement by any member of the profession, especially by a Fellow of the Irish College of Surgeons; but we are now glad to be able to withdraw that censure, so far as publication of an advertisement is concerned, inasmuch as the Mr. Redington has repudiated the transaction in the columns of the paper in which it appeared, and the editor has admitted that Mr. Redington never ordered its publication, but that it was simply a copy of a semi-private circular issued by that gentleman to the Asylum Governors which had been shown to the editor by one of them and converted into an advertisement without any authority whatever, which, we take leave to say, seems to us to be a very strange way of editing a newspaper. We are not however prepared to withdraw our judgment that the manifesto would (even if limited in circulation to the Asylum Governors) be much more suitable "for a village stump politician than to a professional gentleman seeking a public medical office, as it places Mr. Redington's claims almost wholly on the ground of politics and religion, and lays little stress on his competency for the performance of the required duties."

THE COST OF A SMALL-POX EPIDEMIC.

The small-pox outbreak at Hull has been very costly to the people of that town. The Health Committee's expenditure up to the end of December was £28,000, and a further estimate shows that by the end of the financial year £41,000 will have been spent. This takes no account of £12,000 spent by the public in vaccination and revaccination whilst the scare was at its height.

Meetings of the Societies and Lectures.

WEDNESDAY, JANUARY 31ST.

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.)—4.30 p.m. Dr. M. Dockrell: Erythema. (Post-graduate Course).

THURSDAY, FEBRUARY 1ST.

HARVEIAN SOCIETY OF LONDON (Staford Rooms, Tichborne Street, Edgware Road).—8.30 p.m. Clinical evening.

FRIDAY, FEBRUARY 2ND.

WEST KENT MEDICO-CHIRURGICAL SOCIETY (Royal Kent Dispensary, Greenwich Road, S.E.).—8.45 p.m. Paper:—Dr. S. Sunderland: Some Forms of Pelvic Pain in Women in which the Diagnosis was difficult. Dr. Herschell will demonstrate an Apparatus for Intra-gastric Shampoo, and the Three-way Tap for Lavage of the Stomach.

SOCIETY OF ANAESTHETISTS (20, Hanover Square, W.).—8.30 p.m. Discussion on the After-effects of the Inhalation of Ether on the Respiratory System, opened by Mr. S. Rombold (Leeds).

LARYNGOLOGICAL SOCIETY OF LONDON (20, Hanover Square, W.).—4.30 p.m. Discussion and Vote upon the Desirability of there being separate Sections for Laryngology and Otology at Congresses and Association Meetings. 5 p.m. Cases shown by Dr. L. Lack, Dr. J. Horne, Dr. Cathcart, Mr. Wyatt Wingrave, and Mr. Waggett.

ROYAL ACADEMY OF MEDICINE OF IRELAND.—Section of Anatomy and Physiology Communications.—1. The President: Protamines and their Cleavage Products—their Physiological Effects; 2. Professor Cunningham: Another Model of the Thoracic and Abdominal Viscera from behind; 3. Professor Coffey: Esophageal Glands of a Primitive type; 4. Professor Birmingham: The Form, Position, and Relations of the Stomach in Man; 5. Dr. C. J. Fatten: The Abdominal and Thoracic Viscera of the Gibbon; 6. Professor Birmingham: The Factors which Determine the Form of the Human Caecum.

Appointments.

BLAIR, A. B., M.B., C.M. Edin., Medical Officer for the Banwell (first) Sanitary District of the Axbridge Union.
DECK, E. J., L.R.C.P. Lond., M.R.C.S., Medical Officer for the No. 2 Sanitary District of the Borough of Hastings.
FORREST, J. S., L.R.C.P. Edin., L.F.P.S. Glasg., Medical Officer and Public Vaccinator by the Alnwick Rural District Council.
FRASER, S., M.B., C.M. Edin., Medical Officer for the Edmonton Sanitary District of the Edmonton Union.
HEDLEY, W. F., M.B. Edin., L.R.C.P., L.F.P.S. Glasg., Medical Officer for the Hullaton Sanitary District of the Uppingham Union.

HIGGINS, ALEXANDER G., M.R.C.S., L.R.C.P. Lond., House Surgeon to the West Kent General Hospital, Maidstone.
HOPE, A. A., M.B., B.S. Durh., Medical Officer for the Fifth Sanitary District of the Daventry Union.
LAMONT, J., L.R.C.P., L.R.C.S. Edin., L.F.P.S. Glasg., Medical Officer to the Poplar Workhouse, London.
MCALL, ANTHONY, M.D. Glasg., Surgeon to the Throat and Ear Department, Roscombe Hospital, Bournemouth.
MACKIE, G., M.B., C.M. Aberd., Assistant Medical Officer for the Infirmary and Workhouse of St. George-in-the-East, London.
MANBY, E. P., M.D. Camb., M.R.C.S., D.P.H., an Officer on the staff of Medical Inspectors by the Local Government Board.
NEVINS, J. E., M.B. Lond., M.R.C.S., Medical Officer for the Workhouse, Liverpool.
PARSONS, H. F., M.D. Lond., M.R.C.S., D.P.H. Camb., Assistant Medical Officer and Medical Inspector for General Sanitary Purposes to the Local Government Board.
PERCIVAL, A. S., M.B. Camb., Honorary Surgeon to the Newcastle Eye Infirmary.
RHYS, WATKIN LLEWELLYN, L.R.C.P. Lond., M.R.C.S., Medical Officer for the Alderley District of the Merthyr Tydfil Union.
RIDLEY, WALTER, M.B., M.S. Dunelm, F.R.C.S. Eng., Surgeon to the Royal Infirmary, Newcastle-on-Tyne.
SMALLWOOD, SAVAGE, M.A., M.B. Oxon., F.R.C.S., Surgeon to the Wolverhampton Hospital for Women.

Vacancies.

Bath General or Royal Mineral Water Hospital, Bath.—Resident Medical Officer, unmarried. Salary £100 per annum, with board and apartments.
Bootle Borough Hospital, Liverpool.—First and Second House Surgeons. Salaries, senior £80, senior £50 per annum, with board, lodging, and washing. Apply to the Chairman, Bootle.
Borough of Southport.—Medical Officer of Health for the Borough. Salary £500 per annum. Apply to the Town Clerk, Town Hall, Southport.
Castletar Union.—Trained Night Nurse. Salary £60 per annum, with rations, and an apartment, fuel and light. Applications to Thomas M. Quinn, Clerk of Union. (See advt.)
City of Liverpool.—Assistant to the Medical Officer of Health. Salary £350 per annum, subject to certain conditions. Applications to the Town Clerk, Town Clerk's Office, Liverpool.
Gorey Union.—Camolin Dispensary. Medical Officer. Salary £120 per annum, with £15 a year as Medical Officer of Health and registration and vaccination fees, &c. Applications to R. Creighton, Clerk of Union. (See Advt.)
Grove Hall Asylum, Bow, London.—Junior Assistant Medical Officer. Salary at the rate of £120 per annum, with board, apartments, washing and attendance.
Hulme Dispensary, Dale Street, Stretford Road, Manchester.—House Surgeon. Salary £130 per annum, with apartments, attendance, coal, and gas.
Killadysert Union.—Trained Nurse. Salary £45 a year, with rations and apartments. Applications to Patrick Macmahon, Clerk of Union. (See advt.)
Loughborough and District General Hospital and Dispensary, Loughborough.—Resident House Surgeon. Salary £100 per annum, with furnished rooms, attendance, and board.
Nottingham City Asylum.—Second Assistant Medical Officer, unmarried. Salary £125, with board, apartments, and washing.
Nottingham General Dispensary.—Assistant Resident Surgeon unmarried. Salary £140 per annum, all found except board.
Royal Infirmary, Sheffield.—House Surgeon for three years. Salary £120 per annum, with board, lodging, and washing.
Ventnor Royal Hospital for Consumption and Diseases of the Chest.—Assistant Resident Medical Officer. Salary £100, with board and residence. Apply immediately to Dr. Parry. (See advt.)

Births.

MACLEOD.—On January 24th, at Harley Street, London, W., the wife of J. M. H. MacLeod, M.D., of a son.

Deaths.

ALEXANDER.—On January 26th, at Loup, near Ardrrossan, N.B., Surgeon-Major Alex. C. A. Alexander, of boydstone Army Medical Service, aged 45 years.
BOND.—On January 13th, at Greenwich Infirmary, Harry Bond, M.R.C.S., L.R.C.P. (St. Bartholomew's Hospital), of pneumonia after a short illness, aged 26 years.
BURGER.—On January 21st, at Finbury Square, London, Alexander Burger, M.D., suddenly aged 61 years.
CRISP.—On December 11th, 1899, at Newcastle, New South Wales, Thos Crisp, M.B., M.R.C.S., late of Chelsea.
DUNBAR.—On January 19th, Robert Pearson Dunbar, M.D., Park House, Blackburn.
EASBY.—On January 23rd, William Easby, M.D., L.R.C.P., L.M., L.R.C.S., of 6, Chatsworth Road, Brondesbury, N.W., late of Peterborough, aged 55 years.
HUGHES.—On January 22nd, at 40, Langham Street, Portland Place, London, Professor David Edward Hughes, F.R.S., aged 69 years.
HULME.—On January 25th, at 18, Philbeach Gardens, South Kensington, Edward Charles Hulme, F.R.C.S., aged 78 years.
POPHAM.—On January 24th, at his residence, 67, Bartholomew Road, London, N.W., after a short illness, Robert Honner Popham, M.D. St. And.
VERNON.—On January 16th, at Shipbrook, Cambridge Road, Southport, Henry Hannonite Vernon, M.D., F.R.S.E., aged 68 years. For 27 years Medical Officer of Health for Southport.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXX.

WEDNESDAY, FEBRUARY 7, 1900.

No. 6.

Original Communications.

SOME REMARKS ON THE OPERATIVE TREATMENT OF UTERINE FIBROIDS. (a)

By W. J. GOW, M.D.,

Physician-Accoucheur to Out-patients, St. Mary's Hospital; Obstetric Physician to the Royal Hospital for Children and Women, and to the Metropolitan Hospital.

FIBROID tumours of the uterus are, unfortunately, of very frequent occurrence, and whilst on the one hand they may sometimes lead to but little trouble, they may on the other, seriously threaten life. Most often, however, they are a source of serious discomfort and ill health without actually endangering life, and though in a considerable number of cases the symptoms which they give rise to can be relieved to a very remarkable extent by medicinal treatment, yet it not infrequently happens that the relief is only partial, and sometimes no real improvement follows even the prolonged use of drugs. The question of operative treatment therefore becomes an important one, and there can be no doubt that of all the operations devised for dealing with this condition, hysterectomy is the one that is most certain to give complete and permanent relief. The chief factor which has kept this operation under has been the high mortality which has attended upon it, and even now by many it is regarded as one involving great risk. The sphere of usefulness of this operation would be greatly increased if it could be shown that the mortality from it need not necessarily any longer be a high one. The mortality of the operation for the removal of a uterus which is the seat of fibroid tumours is a matter, to my mind, of the utmost importance, because on the mortality of the operation turns the whole question of the indications for hysterectomy. So long as the mortality of the operation remained as high as 20 per cent. it is obvious that it was impossible to advocate removal unless as a last resort, and the patient was well-advised to put up with the troubles she had, rather than run the very considerable risk of losing her life which the operation exposed her to. It has often been insisted upon that fibroids seldom threaten life, but it is equally true that they often reduce the possessor of them to a condition of chronic invalidism, although after years of waiting the menopause may arrive and bring with it some measure of relief. If hysterectomy had no mortality, or if the mortality was very low, it is clear that the operation might be honestly recommended in cases where although the life of the patient was not threatened, the health was so seriously affected as to lead to inability to perform the ordinary duties of life with pleasure or efficiency. To a poor woman

who is in part or entirely dependent on her own exertions, long continued ill-health, resulting from excessive monthly losses of blood, is a serious matter, and the consequent inability to gain her livelihood renders waiting for the menopause an irksome or impossible task. Even among the well-to-do classes the loss of the best years of their life is hardly to be contemplated with equanimity, and if by a comparatively safe operation complete and permanent cure can be obtained, it is hardly fair to restrain them from seeking it. It is quite true that if the immediate risk to life from an operation is great it is better to wait rather than to run such a risk, so that the whole question of operative treatment turns on what that risk is.

The operation of abdominal hysterectomy will always be a formidable one, and often a difficult one, and one never to be undertaken lightly. A certain amount of shock is hardly to be avoided, and the opening up of connective tissue spaces will make blood poisoning easy unless sufficient precautions are taken. If, however, the seriousness of the operation is fully realised and every precaution which modern science has shown to be essential is taken, the risks of this operation may be reduced almost to a vanishing point. The operation is often not simple and not easy, and if performed by those inexperienced in abdominal surgery or in unsuitable surroundings or without every antiseptic precaution it will still undoubtedly be attended by a disastrously high death-rate. In such an operation as hysterectomy the penalty of inattention to detail is heavier than in the simpler one of ovariectomy. It is not uncommon for operators to still talk of a mortality of 10 per cent. as if it was a necessary evil which could not be avoided, but such a death-rate is a very terrible thing, and it is only when we realise the fact that there is no legitimate mortality in hysterectomy or any other operation that it will be reduced to within reasonable limits. An occasional accident will, I suppose, be always liable to occur, but apart from such a misfortune there should be, and I believe in time there will be, no mortality at all as the result of surgical operations.

If fatal cases are carefully studied, and they deserve study as much or more than those which are successful, the operator will generally be able to find out the reason in some fault of omission or commission, or if at a loss to do so he may with advantage seek the opinion of any experienced and candid friend who was present at the operation.

As to the relative advantages of the extra and sub-peritoneal treatment of the stump, the whole question again turns on the relative mortality of the two operations. Life is a more important consideration than any other, and if more patients live after the use of the serrenuud than after dropping back the stump into the abdomen no reasonable person would adopt any other method. It is for the advocates of the sub-peritoneal plan to show that their mortality is as low as that of the advocates

(a) Read before the Medical Society of London, January 8th, 1900.

of the older extra-peritoneal method, and it is on the question of mortality and on nothing else that either operation can claim to rise or fall. It is not necessary to show that the mortality of the sub-peritoneal method is lower than that obtained by the use of the serrenœud, because the former possesses certain intrinsic advantages of its own, such as a more comfortable convalescence and a firmer abdominal scar. Personally, I am a strong advocate of the sub-peritoneal plan, and in my own experience the mortality from this operation has been much less than that of the extra-peritoneal, and it has a further great advantage in that it is applicable to all cases. This is a very important point, because I do not think it can be said of any of the other radical operations for the removal of a fibroid uterus, such as pan-hysterectomy. Since September, 1895, I have employed this method in all cases of abdominal hysterectomy for fibroids, and during that time I have never had to fall back on oöphorectomy as a substitute. That is to say that in all cases where I set out with the object of performing an abdominal hysterectomy I have always been able to do it by this method. I cannot help thinking that those surgeons who habitually use the serrenœud meet from time to time with cases, where, owing to the absence of any kind of pedicle, they content themselves with removing the ovaries instead of removing the uterus. In my series of forty-seven cases, which form the basis of my remarks this evening, there has been no selection; they represent the entire number of patients (both hospital and private) on whom I have operated for uterine fibroids during the last four-and-a-half years with the exception of three or four cases, where vaginal enucleation was practised for the removal of purely submucous tumours. During that period I have never done an oöphorectomy in a case of fibroids. In all the cases the uterus with the tumour or tumours was removed at the level of the os internum, and the stump after being dealt with in the ordinary way, was dropped back into the abdomen. Drainage was only employed in one occasion (Case 40), the details of which I shall narrate shortly.

Among those forty-seven cases there has been one death (Case 8), and the table shows a series of thirty-nine consecutive cases of recovery, giving a total mortality of just over 2 per cent. My excuse for bringing forward this series of cases is that I hope to prove that abdominal hysterectomy properly performed is not so dangerous an operation as it is generally thought to be, and further that the sub-peritoneal treatment of the stump gives as good, or I believe better, results than any other plan. At a meeting of the Obstetrical Society of London held in November, 1897, Mr. Bland Sutton read a paper entitled, "On Abdominal Hysterectomy for Myoma of the Uterus; with brief notes of twenty-eight cases." In all these cases the sub-peritoneal plan of treating the stump was adopted. Two of the cases died, but he was able to show a series of twenty consecutive recoveries. Mr. Meredith, in the discussion which followed, stated that the serrenœud had given him 83 recoveries out of a succession of 90 abdominal hysterectomies (a mortality of 7.7 per cent.) including a run of 30 cases without a fatality. He claimed at that time that these results had not as yet, as far as he knew, been equalled by the advocates of the sub-peritoneal method. As I have shown in my own series, these results, admirable as they are, cannot only be equalled, but can be surpassed by the sub-peritoneal method, and no doubt Mr. Sutton and others could now produce series of cases considerably longer than my own in support of the same view, though as far as I know, no such tables have been published in this country up to the present time. It is often said that

the lessened mortality of to-day in such operation is due to the fact that it is done early, when the tumour does not reach higher than the navel. Although I certainly advocate the removal of tumours of this size under certain circumstances, I am sure that the operation is no easier than when the tumour is large and fills the abdomen, and this factor cannot be called in to account for the small mortality. In fact, speaking broadly, the larger the tumour the easier it is to remove, and an easy operation means a shorter operation, and therefore a lessened amount of shock. The success of this operation depends on two things, and two things only, viz., strict cleanliness and complete control of bleeding vessels.

INDICATIONS FOR THE OPERATION.

Even though the mortality of abdominal hysterectomy is reduced to 2 per cent. or less, it is obvious that we cannot recommend such a form of treatment in all cases of uterine fibroids. At a rough estimate probably not more than 10 per cent. of all cases of fibroids call for an operation such as this. Presuming for a moment that the mortality could be kept as low as this, even then it is not easy to lay down very definite rules as to the indications for operation. Large size, rapid growth, free hæmorrhage, great pain, or serious pressure symptoms are obvious indications. Pain is not a very common symptom of fibroids, but if present is, in my experience, generally incapable of relief by drugs. In its most severe form it is generally due to one or other of the fibroids projecting into the uterine cavity, and exciting irregular and painful contractions of a labour-like character.

The condition of life and the character of the patient must be taken into consideration, as has already been mentioned, poor women cannot afford to be partial invalids, and to some of those in easy circumstances ill-health is very irksome. To these, operation may be recommended, though the symptoms are not severe enough to justify one in urging it as a necessity. To some women, on the other hand, an operation presents so many terrors, that they prefer to remain as they are so long as their life is not actually threatened. In many cases all one can do is to point out to the patient that her choice lies between putting up with the symptoms she has got, or submitting to an operation, which is obviously not devoid of risk, but which, if successful, will result in a complete cure.

Tumours that fill the pelvis generally require removal sooner or later, and if they are already causing discomfort there is no object in waiting.

A question that it is often useful to ask oneself is whether it is probable that the patient will be able to go through the rest of her menstrual life if nothing is done. If the answer is in the negative then there seems to me to be really no object in postponing what later will become an operation of necessity. For instance, a woman, æt. 35, has a fibroid which reaches to the umbilicus, and is already the cause of some pain and a free monthly hæmorrhage, and medicinal treatment gives but little relief. It is extremely improbable that she will be able to pass through the next fifteen years of her life with even a reasonable amount of comfort, although the urgent need for an operation may not arise until she is forty-two or forty-three. With great care she may be able to hold out till then, but during that time she will have to live the life of an invalid. As the mortality now stands, I think it is better to advise an immediate operation and thus avoid the loss of many years of activity. It is true, as already pointed out that it is no safer, and no easier to remove a fibroid uterus at this stage than it will be when it is twice the size, and even the anaemia produced by the loss of blood does

not, unless very extreme, appreciably increase the risk of operation. But it puts the patient back into the world again at five-and-thirty instead of at five-and-forty, when invalid habits may very probably have become confirmed.

To sum up, the lessened mortality of abdominal hysterectomy enables one not merely to save patients from death but to save them from invalidism. Any patient who is seriously incommoded by a fibroid which does not yield to treatment and is not suitable for enucleation through the vagina, may fairly be advised to submit to an abdominal hysterectomy with sub-peritoneal treatment of the stump, provided the would-be operator has reduced his mortality to below 5 per cent. My own method of operating in these cases differs slightly from that employed by many others, and I therefore venture to describe the plan as now adopted by me, which I find applicable to all cases.

Various minor details have obtained a fictitious importance. Baer, for example, insisted that no ligature should be passed through uterine tissue, and attributes some of his success to this rule. Others have insisted on the importance of excising or sterilising the cervical mucous membrane. In the last 39 cases I have invariably ligatured uterine tissues, although the uterine arteries have been controlled by a separate ligature, and I have hardly ever excised or treated the cervical mucous membrane.

The plan of procedure has not been uniform because with increasing experience certain modifications have naturally crept in. In the last 30 or 40 cases the following plan has been adopted. After the peritoneal cavity is opened the tumour, when possible, is drawn out through the abdominal incision. If the broad ligaments are very short or the tumour is mainly intra-ligamentous and intra-pelvic, it sometimes happens that this cannot be done at this stage. Under any circumstances the first step in the operation is to ligature each round ligament about on a level with the os internum. The anterior flap of peritoneum is then marked out with a knife, and the round ligaments are divided on the uterine side of the ligature. This opens up the broad ligament, and with scissors the anterior layer may be divided, carrying the incision up towards the middle of the Fallopian tubes. The incision across the front of the tumour must be made sufficiently high to allow of the formation of a large anterior flap, and this flap is now stripped down with the fingers or the handle of a knife. The ovarian arteries and veins are next tied on each side by a ligature, which includes the Fallopian tube. This ligature, at any rate on one side should be tied so that at least one ovary is left, but if the fibroid occupies one broad ligament it is often more convenient to tie it on this side outside the corresponding ovary. Both ovaries should never be removed unless they are the seat of serious disease. Having tied the ovarian vessels on each side the broad ligament is divided on the uterine side of the ligature. Clamp forceps may be used to check the oozing which comes from the uterine end of the divided tissue. This is done on both sides, and then the posterior flap is marked out with a knife and dissected downwards for a short distance. The uterine arteries can now be generally felt without difficulty, and may be seized with a pair of pressure forceps at the level of the os internum. The tumour is now cut away with a knife, at the appropriate level, and the stump caught up and drawn to the surface with volsellum forceps. The uterine arteries are now carefully tied. This plan takes less time than if the arteries are tied before the tumour is cut away.

After this has been done I always introduce what I call a precautionary ligature, a curved needle on a

handle armed with silk is thrust through the stump from before backwards, avoiding the peritoneum so as to allow the ligature to include in its grasp the outer growth of the stump. This is tied on the outer side, and includes the uterine artery which, however, has already been tied separately. A similar ligature is now tied on the other side. The object of these ligatures is to control oozing from the cut surface. Vessels are given off obliquely, not horizontally from the uterine artery and, therefore, although this artery has been tied on the level of the cut surface of the stump there may be some bleeding point owing to a branch springing off from the main artery below the point where it is secured, and running upwards and inwards. Such vessels are often seen especially on the posterior half of the stump. By this means all oozing or spurting, as the case may be, is generally stopped at once, and even if there is no oozing it is a safe precaution as no harm results from thus enclosing uterine tissue in a ligature. Vessels in the substance of the cervix should never be tied on the face of the stump, as the ligatures will almost certainly come off. If oozing continues as it will sometimes in a very vascular stump a curved Hagedorn's needle may be used to encircle the bleeding area, and the tissue and vessels compressed with a ligature.

I think these additional precautionary ligatures are of value, because in the one fatal case which I have had (Case 8), death resulted from secondary hæmorrhage thirty-six hours after the operation as the result of the slipping of a ligature applied to a small vessel on the posterior part of the stump. In this case both uterine arteries had been tied in the ordinary way, but no precautionary ligatures had been used. At the post-mortem examination the uterine and ovarian arteries were securely tied, but about a pint of blood had escaped from a vessel on the posterior part of the stump which, at the time of the operation had been secured by a superficial ligature. Since then I have always employed these lateral ligatures and have never found that they have caused the least harm, and they afford a rapid and effectual means of checking oozing. In no case have I ever seen any ligatures discharged either through the abdomen or through the vagina.

In the fatal case above-mentioned the patient did very well for the first 36 hours, but in the middle of the second night she suddenly became faint and showed symptoms pointing to internal bleeding, and sank in a few hours before I had the chance of seeing her. I may add that probably the best way of dealing with secondary hæmorrhage from the stump if it does occur would be to excise the stump per vaginam, using clamps to control the uterine arteries. This would entail considerably less shock than reopening the abdomen and could be done rapidly.

After the oozing has been stopped I generally put in two fore and aft sutures through the muscular substance of the stump, again avoiding peritoneum, and in this way the raw surface is rolled together. They probably are of no great importance, but they serve to hold the stump up with, whilst the peritoneal flaps are united. After this has been done the peritoneum is cleansed, and the abdomen closed.

May I offer a plea in favour of the simplification of abdominal operations. Personally I seldom use more than six pairs of pressure forceps, and never more than six sponges. Further, I never have more than one assistant, and I never allow anyone but myself to touch my instruments and ligatures. I will not trouble you with other details as regards the management of sponges, but I hold that as few people should come within the circle of the operation as possible.

The desirability of leaving the ovaries seems still to be doubted by some, and we are told that after

the removal of the uterus they undergo slow atrophy, and thus a real menopause develops in spite of their presence. Even if this is the case it is still, in my opinion, highly desirable to leave one or both of them because by so doing the acute development of the climacteric is avoided. During the gradual atrophy the climacteric disturbances are in no way greater than when they supervene as the result of a gradual loss of physiological activity. Although I have not been able to follow all my cases since operation, yet I have seen many of them, and in no case have I met with any serious mental or bodily disturbance such as so often follows after oophorectomy.

The most serious complication at the time of operation is the presence of old adhesions between the enlarged uterus and the adjacent structures such as may result from a previous attack of perimetritis, secondary to trival disease.

In four of my patients (Cases 36, 39, 40, 42) a single or double pyosalpinx existed, and inasmuch as this condition is somewhat rare, I propose to narrate briefly the chief features of these cases.

Case 1.—This case was first seen by me on January 9th, 1899, in consultation with Dr. Sunderland. The patient was a widow and had never been pregnant. During the previous October and November she had suffered from abdominal pain accompanied by some pyrexia, and had been obliged to remain in bed for several weeks. On December 24th, she was suddenly taken ill with severe abdominal pain and vomiting, and the temperature rose to 104 degs. F. Since then the pain had become less severe, but the temperature still remained between 100 degs. and 101 degs. The patient was markedly anæmic and the monthly periods were profuse. On examination, a fibroid tumour was found reaching up to the umbilicus, but nothing further could be made out.

The operation was performed on January 12th, 1899, in a nursing home. Both tubes were found to be enlarged and adherent and contained pus. Both ovaries were enlarged to the size of hen's eggs and contained pus. The enlarged ovaries lay deep down by the sides of the supra-vaginal cervix. The uterus was first cut away to give more room, and then the appendages were dug out after much difficulty. Pus escaped from both tubes and ovaries during removal. No drainage was employed. Convalescence was normal.

Case 2.—This patient, æt. 50, was admitted to the Royal Hospital for Children and Women in June, 1899, complaining of profuse irregular hæmorrhage. A large tumour the size of a six months' pregnancy occupied the abdomen. On vaginal examination a tumour the size of an orange could be made out in Douglas's pouch, and another similar tumour lay in front of the cervix. At the time of the operation the abdominal tumour was found to be the enlarged uterus, and the other two tumours were the Fallopian tubes distended with pus. The uterus with both ovaries and tubes were removed. The convalescence was remarkably smooth.

Case 3.—This patient was æt. 35, and was seen by me with Dr. Squire at the Paddington Infirmary. She had been taken ill three weeks before admission with severe headache and abdominal pain, and a week later she became delirious and remained so till after the operation. When seen by me the abdomen was distended and tender, the temperature was raised, the tongue was dry and brown, and there was noisy delirium. A fibroid tumour reached as high as the navel. The cause of her illness was obscure, but as her condition was very grave an operation was decided on. I performed hysterectomy on July 3rd, and both appendages were then found to be enlarged and very adherent. They were removed with great difficulty, and found to contain offensive pus. There was free oozing from the pelvis and a drainage tube

was therefore inserted. The oozing continued for the first twenty-four hours after the operation. Two days later the discharge from the tube became offensive and remained so for several days, but ultimately the patient got quite well.

A TABLE OF FORTY-SEVEN CASES OF ABDOMINAL HYSTERECTOMY FOR FIBROIDS WITH SUB-PERITONEAL TREATMENT OF THE STUMP.

Case.	Age.	Date.	Place of Operation.	Result.	
1	39 M	Sep. 24, '95	St. M H	R	Very large tumour. Ovaries removed
2	41 S	Oct. 29, '95	R H C W	R	Ovaries removed with tumour
3	25 M	Feb. 18, '96	"	R	Ovaries removed with tumour
4	40 S	April 15, '96	M H	R	Ovaries left
5	48 S	April 28, '96	R H C W	R	Ovaries left
6	27 M	May 5, '96	"	R	Tumour mainly intraligamentous
7	33 M	June 30, '96	"	R	Part of tumour gangrenous
8	48 W	Aug. 8, '96	M H	D	Death from secondary hæmorrhage
9	44 W	Aug. 14, '96	R H C W	R	Ovaries cystic: removed with uterus
10	42 M	Aug. 25, '96	"	R	Tumour partly intra-pelvic
11	38 M	Sep. 1, '96	St. M H	R	Large myoma; 3 months pregnant
12	35 M	Sep. 8, '96	R H C W	R	Tumour intraligamentous
13	29 S	Sep. 16, '96	"	R	Large soft myoma
14	37 M	Sep. 19, '96	"	R	Tumour intraligamentous
15	36 M	Sep. 28, '96	St. M H	R	"
16	35 M	Oct. 8, '96	R H C W	R	Partly intra-pelvic. Double hydro-salpinx
17	36 M	Dec. 8, '96	"	R	8 mos. pregnant. Child removed by cesarean section. Uterus and fibroids removed
18	40 M	Mar. 2, '97	St. M H	R	"
19	47 M	Sep. 1, '97	M H	R	"
20	44 S	Sep. 2, '97	R H C W	R	Tumour partly intra-pelvic
21	38 M	Oct. 1, '97	Private	R	Very anæmic
22	47 S	Nov. 23, '97	R H C W	R	Tumour intraligamentous
23	36 W	Jan. 25, '98	"	R	"
24	35 M	Feb. 26, '98	"	R	Intraligamentous; cystic
25	45 W	Mar. 29, '98	"	R	Very anæmic. Tumour intraligamentous
26	32 S	April 26, '98	"	R	Tumour intraligamentous
27	46 S	May 17, '98	"	R	"
28	43 W	June 4, '98	"	R	"
29	40 M	July 13, '98	"	R	Very anæmic
30	45 S	Oct. 4, '98	"	R	Tumour intraligamentous
31	41 M	Nov. 1, '98	"	R	Very anæmic
32	48 W	Nov. 23, '98	M H	R	Profuse menorrhagia
33	32 S	Nov. 25, '98	Private	R	Menorrhagia. Pain
34	49 M	Jan. 3, '99	R H C W	R	"
35	51 M	Jan. 6, '99	"	R	Severe pain. Menorrhagia
36	44 W	Jan. 12, '99	Private	R	Pus in ovaries and tubes
37	38 S	April 12, '99	M H	R	Very anæmic
38	48 S	April 24, '99	R H C W	R	Large cystic fibroid
39	50 M	June 16, '99	"	R	Double pyosalpinx
40	35 M	July 3, '99	Paddington Infirmary	R	"
41	42 M	Aug. 31, '99	St. H M	R	Double pyosalpinx
42	42 M	Sep. 14, '99	"	R	Tumour partly intra-pelvic
43	45 M	Sep. 26, '99	R H C W	R	Left pyosalpinx
44	44 M	Oct. 11, '99	"	R	"
45	35 S	Oct. 31, '99	"	R	Very large tumour
46	40 S	Nov. 1, '99	Private	R	"
47	38 M	Dec. 12, '99	R H C W	R	Four weeks ovum in uterus

St. M H—St. Mary's Hospital. M H—Metropolitan Hospital.
R H C W—Royal Hospital for Children and Women.

Case 4.—The patient was 42 years of age, and was admitted into St. Mary's Hospital for severe menorrhagia and abdominal pain. There had been pyrexia for some weeks before admission and the patient was very ill. There was a fibroid tumour which reached up to the navel, and in the left posterior quarter of the pelvis a smooth elastic swelling could be felt, the size of a hen's egg. At the operation, September 14, 1899, the left tube was found converted into a pyosalpinx. It, together

with the uterus, was removed. Both ovaries were left. There was a good deal of oozing from torn adhesions, but no drainage was employed. The patient made a good recovery.

It has been impossible in the time at my disposal to do more than touch on some of the points of interest in connection with this subject, but my chief object has been to support the view that of all the radical operations for fibroids, abdominal hysterectomy with sub-peritoneal treatment of the stump is the best and the safest, and that this operation may confidently, in the future, be looked to to give a mortality of not more than 1 or 2 per cent.

THE DILATATIONS AND DIVERTICULA OF THE ŒSOPHAGUS.

By JOHN KNOTT, M.A., M.D., CH B., and Dip.
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IN the issue of THE MEDICAL PRESS AND CIRCULAR bearing date December 27th, 1899, there appeared a short article under the head of "Notes on Current Topics," under the title of "Sacculated Diverticula of the Gullet." The general tone of this article, and the well-known fact that all pathological conditions of the œsophagus are, comparatively speaking, of great rarity, have led me to think that the publication of my notes on the various forms of dilatation of the walls of this important tube might not prove unwelcome to the readers of the journal.

In one of the issues of the years of infancy of THE MEDICAL PRESS AND CIRCULAR (January 27th, 1841), a report will be found of a lecture delivered to his class by Dr. Charles Benson, then Professor of Medicine in the Schools of Surgery of the Royal College of Surgeons in Ireland, and Physician to the City of Dublin Hospital, where his reputation has been so well sustained in the present generation by his sons—Dr. Hawtrey Benson, who is now its consulting physician, and Mr. Arthur Benson, its distinguished oculist. At that date, the dawn of the golden era of Irish Medicine, it is interesting in the present connection to find the following remarks recorded in the language of one of its most brilliant representatives:—"An organ so well supplied with arteries and nerves may be conceived to be liable to inflammatory and nervous affections. Its muscular coating exposes it to spasmodic affections, its strong cellular or nervous coat to more permanent contractions, and the exposure of its mucous membrane to all the varieties in the temperature, and in the other qualities of bodies with which it is incessantly coming in contact, might be expected to render it very subject to disease, yet I cannot say that it is very subject to disease of any kind. Walk through the hospitals in Dublin for weeks together, and in the long catalogue of diseases you may not see one of the œsophagus."

Diseases of this portion of the body do, however, occasionally occur, and with, as might be anticipated, peculiarly fatal results. And the malformations and dilatations of which it is sometimes found to be the seat, are, perhaps, pathologically unique in this peculiarity of being more painful than, and almost as surely fatal as, the most malignant structural changes known to affect its walls.

Returning now to the section of œsophageal pathology with which the text of the present communication is more immediately concerned, I propose to divide these abnormal conditions of the gullet into *congenital* and *acquired*. The varieties of each of

these divisions may in turn be very conveniently and scientifically arranged, in accordance with the classification of Rokitansky, under three heads:—

1. The *cylindrical* or *fusiform*, in which a great part of the length of the tube is engaged; or, as sometimes happens, the whole length of the pharynx and œsophagus presents this modification.

2. The *sacciform*, in which pouches (one or more) are found, which involve all the coats of the œsophagus.

3. The *hernial*, in which the mucous membrane alone expands; and this coat, protruding through the muscular layers, forms *diverticula* or *herniæ*.

The first variety is rarely met with, whether the abnormality be congenital or acquired. In the recorded cases, the amount of dilatation has been, however, generally very great.

The accompanying illustration (Fig. 1) is copied from Virchow's Archiv (Bd. XLII., Taf. XI.), and pictures a case of enormous fusiform dilatation of the œsophagus, recorded by Luschka, which was not accompanied by any appreciable narrowing of the cardiac orifice, compression, or other obstruction in its vicinity.

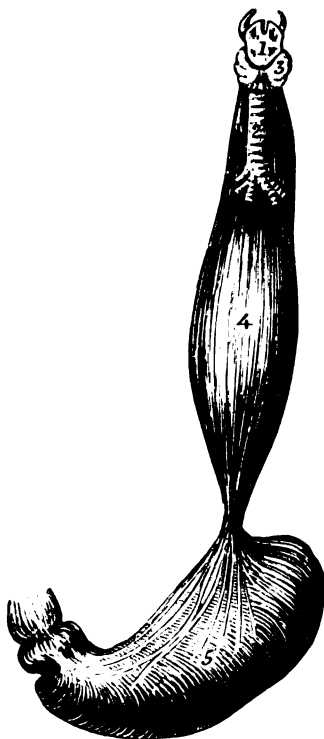


Fig. 1.

The specimen had been removed from the body of a woman, æt. 50, who had had, from the age of 15, the power of vomiting at will. During the latter years of her life she had often vomited blood. The œsophagus was found to be 40 c.m. in length, and 30 c.m. in circumference at the widest part. The muscular coat was greatly hypertrophied. The mucous membrane seemed to have been the seat of acute catarrhal inflammation. There is no doubt in my mind that this case originated in congenital abnormality.

A case of simple dilatation of the œsophagus was met with by Zenker in a seven months' babe, which survived its birth only to the seventh day. Had it survived for some years I have little doubt that it would have grown into something like the original of the above figure.

The most instructive case of this kind which, so far as I can find, has hitherto seen the light, is one in which the patient had lived to old age, but had

suffered all through life from the symptoms of œsophageal obstruction. The abnormal œsophagus was brought under the notice of the Pathological Society of London (May 1, 1866) by Dr. (now Sir) Samuel Wilks, who was then rapidly growing in the fame, as pathologist and physician, which his subsequent career has so well sustained. The patient had been under the care of Dr. Rootes, of Ross, for whom the specimen was shown.

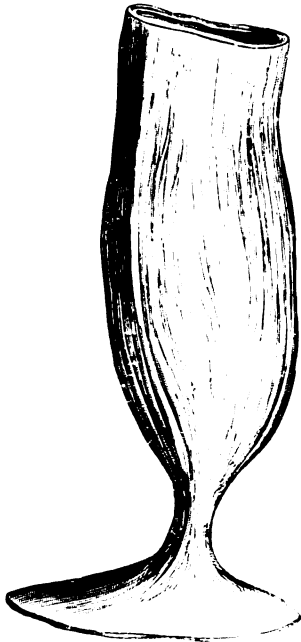


FIG. 2.—Dr. Wilks's case of dilatation of the œsophagus. At the upper end the thickness of the coats is intended to be shown in section. At the lower end is seen the narrowing of the tube just above its junction with the stomach.

"The specimen had been taken from the body of a man of seventy-four who had died of pneumonia. He had suffered all his life from dyspepsia. He had consulted Sir A. Cooper for this forty years before. He had always been obliged to eat slowly and carefully, and to wash down each bolus with a draught of fluid. He never partook of a meal of which he did not bring back some portion, so that he had been, in fact, a ruminating animal. The œsophagus was as large as an ordinary-sized colon, and its calibre was pretty uniform throughout. It was six-and-a-half inches in circumference in the undistended state. The cardiac orifice was narrower than usual, barely allowing a finger to be pressed through, but there was no trace of disease to account for this contraction. The walls of the tube were very much thickened by increased muscularity. The stomach was normal." The accompanying woodcut figure is that of the specimen. (From "Guy's Hospital Reports," Vol. XVII., 417.)

The patient himself used to account for the origin of his condition by his straining himself in the manipulation of heavy weights. Dr. Wilks had no doubt that the dilatation had been congenital. The existence of a congenital cardiac constriction, which seems highly probable, would, of course, have continuously aided in the gradual expansion of this enlargement, which was almost certainly only slight at the period of birth. This view appears to me to be very much strengthened by the fact of the co-existing hypertrophy of the muscular walls, which must have been produced by the ever-recurring abnormal effort required to overcome a fixed obstacle.

In such cases the muscular coats of the tube are found to be hypertrophied, whereas in those of acquired—secondary—dilatation, the opposite condition of atrophy—with attenuation—is very often met with.

Sacciform dilatation of the œsophagus, although an infrequent, is a well-known condition. In a large proportion of these cases, the abnormal form of the expanded portion of the tube has represented pretty accurately the auxiliary digestive pouch which is found in birds—the "crop" of the Hibernian poultry-yard, "crop" of the up-to-date cookery-book, and *ingluvies* of the ornithological anatomist.

Specimens of this congenital abnormality have been placed on record by Grashuys and by Vicq-d'Azyr. I am inclined to think, with Mondiere, that a large proportion of the cases of dilatation of the œsophagus which have been observed in later life, really originated in some such congenital disposition, which served as a starting point, and which afterwards became exaggerated by the detention of food.

An interesting case of dilatation was published by Dumas (*Recueil periodique*, XXIII., 59), in which the lower portion of the tube was engaged. He believed that the origin was a congenital malformation. The ultimate development was such, however, as to suggest to him a very strong resemblance to the first stomach of a ruminating animal.

A similar form of abnormality has been recorded by M. Della Chiaga, of Naples. An enormous dilatation of the lower part of the œsophagus was found, "forming a tumour, or rather a pouch analogous to the first stomach of ruminant animals, and in which the ingesta remained for some time, to be afterwards rejected by a kind of regurgitation. The muscular walls of the pouch were of extraordinary thickness." No definite diagnosis had been made during life: death had closed a period of dreadful suffering, which had lasted many years. M. Della Chiaga believed the origin of the condition to have been a congenital malformation—small at the time of birth, and gradually increasing by yielding to the pressure of retained ingesta.

Blasius (*Obs. Med. Rariores, Amstelodami, 1677*) describes as a specimen of *double stomach* one of which I entirely agree with the opinion expressed by the late Sir Morell Mackenzie, "from his own report, and the rough drawing which accompanies it, was undoubtedly an instance of dilatation of the lower part of the gullet." The original report is as follows:—

"*Ventriculus duplex*.—In dissecto cadavere 35 annorum creberrimis vomitibus diu vexato invenimus Ventriculum duplicem, ita ut *prior*, qui Oesophago continuus, ab *altero* qui intestinis, manifeste distingueretur. Ille minor altero, est crassioris substantiæ, infinitis plicis, iisque insignibus, interior exasperatus, hic verò iis omnino destituebatur, tenuis valde conditionis. In illo fibre carnosæ plurimæ occurrebant varii generis, in hoc vix ullæ, saltèm haud adèò observabiles. Locus ille, ubi duæ hæc cavitates à se invicem separabantur, interior valde angustus erat; sic ut vix digitum minimum reciperet; substantia ipsa hic crassa, duraque admodum, mollioris quasi car ilaginis speciem referens. Et hanc angustiam frequentioris vomitus in hoc agrotante causam fuisse conjicio."

The only confusing element in the above case would appear to be that the dilatation, so far as we can judge from the very sketchy description, seems to have been limited to the sub-diaphragmatic section of the œsophageal canal. The next "Observatio" recorded by the same author is one in which the section of the œsophagus situated between the heart and diaphragm presented a saccular expansion, "quasi Ventriculus."

"De duplicitate stomachi quæ propono, cum fre-

quantius occurrant admirationem haud adeò movent eo, quod non ita pridem videre contigit in dissecto corpore alio Viri toto ætatis tempore valde famelici, alias benè sani. Oesophagus hic, in Thorace, intra Cor and Diaphragma, insigniter dilatus, singulare quasi *Ventriculum* constituebat, utroque enim extremo angustia maxima notabatur, ubi nempe gula hæc dilatari incipiebat, & ubi iterum ad statum debitum accedere. *Kugosa* etiam hæc cavitas intus observabatur, materia ex albo flavescente eaque lentâ satis obducta. Ab hoc Ventriculo per orificium uti diximus summè angustum transitus erat, ad duorum transversorum digitorum distantiam, in Ventriculum verum, qui naturalis omninò constitutionis erat, sive substantiam species, sive locum, aliave."

The language used in the above "report" leads me to think that after all the writer may not have looked upon the sac in the first case as an additional "stomach" in the ordinary anatomical sense of the term. The remarkable feature in the latter case would appear to be the absence of any troublesome symptoms.

The existence of the *third form* of oesophageal dilatation of Rokitsky's classification—in which a sac is found by a *hernial protrusion of the mucous membrane* of the tube through an opening in its muscular coat—has given rise to a good deal of discussion among pathological anatomists. *Monro (Morbid Anatomy of the Gullet and Intestines)* long ago admitted it among the varieties of dilatation met with in this canal, but does not seem to have had any stronger reason for doing so than its analogy with what is sometimes seen in the intestines, and more particularly in the walls of the urinary bladder. He thought that in consequence of a strong spasmodic contraction of the muscular fibres of the oesophageal wall the mucous membrane might be so pressed as to form a hernial protrusion between their bundles, and that the pouch originally so formed went on increasing indefinitely from the pressure of the ingesta which lodged within it. *De Guise* also attributed their origin to a hernia of the mucous membrane which took place during the pressure called forth in the act of deglutition; and he thought that this explained the fact that they are most frequently seen at the junction of the upper end of the oesophagus with the pharynx. He believed that he had seen a case of this kind occurring in a horse, but his own account of his observations does not lead me to believe that he had made a careful dissection of the parts.

Mondiere, in the whole course of his elaborate researches on affections of the oesophagus, did not meet with a single well-authenticated case of the kind. On the other hand, *Crucillier*, as the result of his own observations, concludes, with *Monro*, that hernial pouches are sometimes formed in the oesophageal wall, similar to those found in the rectum and bladder.

A very striking example of this form of pouch-like dilatation was exhibited to the London Pathological Society by *Dr. Ogle*. The specimen was taken from the body of a man, æt. 63, who had died of pneumonia. He had suffered from difficulty in swallowing for many years before his death. When his meals were concluded, small portions of the food used to return into the fauces and buccal cavity, and this process of regurgitation used to continue with more or less activity for several hours. For two or three years before death he had been subject to attacks of laryngitis; from which, however, he had always appeared to recover completely. It had been suggested that a stricture of the oesophagus existed; but no special treatment was ever adopted. On post-mortem examination no stricture was found. The upper part of the pharynx was found to be enlarged, with its muscular fibres greatly hypertrophied, while from the posterior wall of the canal, at the level of the junction of the muscular fibres of the inferior constrictor of the

pharynx with the upper border of the circular muscular fibres of the oesophageal wall, sprang a pouch of about the size of a bantam's egg. This pouch involved only the posterior and lateral portions of the circumference of the tube. It projected downwards behind the oesophagus, and its wall was apparently formed by a portion of the mucous membrane and submucous tissue protruding between the bundle of muscular fibres. It did not appear to contain any muscular fibres in its wall, and this opinion was afterwards confirmed by microscopic examination.

The accompanying woodcut gives a view of the parts from behind. The oesophagus and pharynx have been laid open, and a piece of catheter introduced, to demonstrate the continuity of the tube.

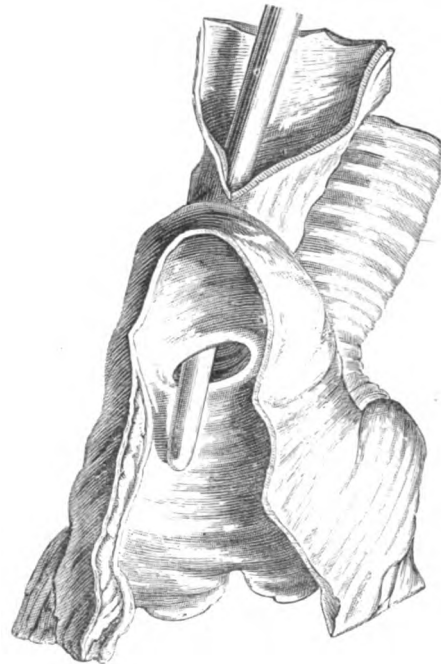


Fig. 3.

The existence of a weak section in the wall of the tube at the junction of the upper end of the oesophagus with the adjacent lower border of the inferior pharyngeal constrictor is known to every anatomist who has made a careful dissection of this region. The unyielding surface of the cricoid cartilage in front must necessarily form an accessory factor in conveying the pressure of a large bolus with specially effective force on this part of the tube. So that the existence of even slight congenital atony in this region must almost certainly proceed to progressive dilatation. A case has been recorded by *Féré* in which one square millimetre of the anterior wall of the oesophagus, near the upper extremity of the tube, was absolutely deficient in muscular tissue. This, in the opinion of *Mackenzie*, "furnishes a possible explanation of the mode of formation of some oesophageal pouches."

Habershon, who adopted *Rokitansky's* classification of dilatations of the oesophagus, also gives an instance which he had met with in *Guy's Hospital*. The patient had died of peritonitis resulting from perforation of the ileum during typhoid fever:—

"At the commencement of the oesophagus was a pouch half an inch in length, consisting of the mucous membrane, and very slightly covered at the neck with a few muscular bands; it was full of mucus. (Prep. 1784.) This form is most frequently

seen near the bifurcation of the trachea: it is found of largest size at the lower end of the pharynx."

A description of a somewhat similar case has been placed on record by Bell. I cannot find in the literature of the subject any definite corroboration of Habershon's statement that such (small) pouches are "most frequently seen near the bifurcation of the trachea."

(To be continued).

CASE OF POSTERIOR (CONGENITAL) LUXATION OF THE SHOULDER JOINT.

By G. BURBIDGE WHITE, M.D., F.R.C.S.,
and Diplomate in State Medicine, Univ. Dublin.

CONGENITAL dislocation of the shoulder is a rare surgical affection, posterior luxation is the most unusual form which it assumes, the usual forms described are of the sub-acromial type. In early infant life it is difficult to recognise, as the superabundance of fat in which the shoulder is encased gives a roundness to the joint which disguises it, and also purposeful motion takes place to a limited extent, little information is obtained from this source.

I. B., *æt.* 11, was brought to me in September, 1898, to see if anything could be done to give him more use of his right arm, which he had not, up to this time; the mother of the boy said that some time after birth it was noticed he did not use his right arm as well as the left, and the opinion was that the nurse had let him fall. Nothing appears to have been done for him till he grew up to about seven years of age, when some doctors in the country were consulted, with the result that the parents were recommended to take the child to Dublin and consult a surgeon there, which was done.

A thorough examination of the joint was made by me on September 1st, with the result that I discovered the following conditions:—There was decided angularity of the right shoulder, with a prominence in front of the shoulder, the head of the bone was absent from the axilla, movement (passive) of the arm caused that of the scapula, total inability to move the arm or forearm, to pronate or supinate, or to flex or extend the hand. The forearm was turned in so that the dorsum of the hand rested on the loin. There it would hang except he moved it with the other hand, in fact, the boy had no idea how to move his upper extremity; if he had, the extreme atrophy of the muscles would have rendered it impossible for him to do so. Considerable atrophy of the head of the bone gave some mobility to the joint. The diagnosis made was: Posterior luxation (sub-spinous, probably congenital), of the acromial end of the clavicle, atrophy of the head of humerus and of the muscles of the extremity, the biceps was remarkable in appearance, being about the size of a walnut when contracted by passively flexing the forearm. The general appearance of the patient suggested a tuberculous diathesis; the right side of the chest was sunken, and a very stooped posture was present; poor appetite and general debility; treatment was undertaken guarded by a cautious prognosis. I have to acknowledge, with thanks, the great help given me in clearing up the origin of this lesion by Mr. Henry Gray Croly, F.R.C.S., Senior Surgeon City of Dublin Hospital, who on inspection pronounced it to be congenital; his ripe experience in surgery inclines me to coincide with this view of the case.

The line of surgery carried out in the case was, in addition to remedying the stoop by a suitable appliance

fitted to the back, holding the shoulders backward, and throwing out the chest, was, first, careful and prolonged massage of suitable kind, carried out by a skilled masseuse, while manipulation of the head into a more forward and better position effected a considerable change in the location of the head, bringing it into a better position so that it could be felt in the axilla, and in this improved position motion of the arm became more possible, independent of that of the scapula, which was fixed by a towel when carrying out passive exercise of the muscles of the upper arm, the muscles of the forearm were similarly treated, and after some months a slow improvement in the size of the muscles was visible, and also in their movements, and by degrees effort was made at voluntary movement of certain muscles by the boy himself. When this had improved considerably, the exercises were extended to the use of dumbbells, and an American elastic exerciser; improvement now became more rapid; when some ordinary movements such as putting on the hat, lifting small weights, &c. were performed. At the end of twelve months there was great progress both in the movements and their extent and power; the muscles had considerably developed, and some of the awkwardness of action had disappeared, the health had shown also marked improvement from the habitual exercises. At the present time, after about twenty months' treatment, it may be fairly stated that a great deal of the use of the arm has been acquired, and the absolute inability to move has given way to quick and well-executed movements, for example, he can dress, put on his collar and tie with both hands, use his knife and fork, put on and take off his hat, &c. and with a little guidance lift his teacup without spilling to his mouth. He is now beginning to learn what it is to have a right arm and hand, and it may be fairly assumed that, with practice, it will not be long before he is in possession of a thoroughly useful right extremity. Skiagraphs and photographs were taken at the different stages of progress, fully bearing out the diagnosis. These, with further notes, on the affection, I hope to bring forward at a future time.

SOME REMARKS ON THE OILS OF CAJEPUT AND CUBEBS AND THEIR USE FOR INHALATION.(a)

By ROBERT J. LEE, M.D. CANTAB., F.R.C.P. LOND.

THE question of how to use certain volatile oils in the form of vapour is one of great interest, and certainly of very great importance. It is a singular fact that when we mix some of these oils with water and then boil, we find that the steam will carry them with it, although the temperature at which the oils boil is very much higher than that of water.

In the case of cajeput oil the boiling point is between 482 degs and 509 degs.; and yet it will evaporate when boiled with water.

What we have to determine, however, is whether the quantity of the oil that evaporates in this way varies in this process; that is to say, whether the oil comes off rapidly like menthol or benzoic acid, and leaves the water soon free of it; or whether only a certain part of the oil escapes, leaving behind a residue. Phenol, some years ago, was shown to evaporate equally with the water, so that we could obtain steam carrying phenol in definite proportion. With cajeput oil I have recently found that we can secure a similar result; and that if we mix two drachms of the oil with half a pint of water, and then evaporate one half of this mixture at 212 de. s., the remaining half will contain one drachm of the oil,

and when the quantity is reduced by further boiling, the water and oil are found to remain in the same proportion.

The oil of cubebs boils between 480 degs. and 500 degs., and so does not differ much in that respect from the cajeput. There is also no very great difference in the specific gravity, that of the former being 0.929 and of the latter 0.885. They both evaporate equally with water.

It appeared to me at one time difficult to understand why we neglected the use of certain medicinal agents in the form of vapour, but the reason became apparent when our want of knowledge of how vapours can be obtained for such use was considered. The conversion of a fluid into a spray is not the same thing as its change into a vapour, and we are still in want of experiments accurately carried out on the best methods of changing certain solids and fluids into vapours, before we can use them in practice. The oils of cajeput and cubebs may be vaporised without difficulty, and as their properties are well understood it is unnecessary to make any remarks on the class of cases in which they may be inhaled with benefit.

Clinical Records.

WESTMINSTER HOSPITAL.

Case of Acute Chorea treated with large doses of Arsenic.

Under the care of Dr. MURRELL.

ADA W., æt. 6, was admitted on November 6th, 1899, with chorea of some weeks' duration. It was her second attack, the previous one, for which she had been in a hospital, having lasted four months. Her symptoms now were perfectly typical, and need no description. There was an mitral aystolic murmur. She was kept in bed and given plenty of good food. Visitors were not admitted. On November 12th she was started on 1 minim of liquor arsenicalis three times a day, and the doses were gradually increased as follows:—14th, 2 minims; 15th, 3 minims; 18th, 4 minims; 21st, 5 minims; 23rd, 6 minims; 27th, 7 minims; 30th, 8 minims; December 6th, 9 minims, all three times a day after meals. There was no improvement in the patient's condition until the 9 minims dose was reached, but a few days later the movement had practically ceased, and on the 15th Mr. H. T. Barron, M.B., who had been keeping careful watch over the patient, discontinued the treatment. On the following day she vomited eight times, there was a copious loose motion, and she complained of pains in the abdomen. On the 15th she vomited only once, but on the 16th she was sick nine times between seven and eight o'clock in the morning. She vomited twice after her dinner that day, and that was the last of the symptoms of arsenical poisoning. There was no dermatitis or pigmentation, there was nothing characteristic about the tongue, and the patellar reflexes, although slightly diminished whilst the patient was under treatment, were never lost.

REMARKS BY DR. MURRELL.

This is an attempt to treat a case of acute chorea according to Murray's method. It will be remembered that Dr. Wm. Murray, of Newcastle-on-Tyne, in his excellent and most suggestive "Rough Notes on Remedies" advocates the employment of fifteen drops of liquor arsenicalis three times a day in all cases of chorea in children. He insists that it should be taken with food, that is, in the middle of a meal. If it does not cure the patient in a week it must be dropped, as the toxic action of the drug would show itself. In this particular case we did not strictly follow Murray's directions. We gave too small doses, and kept up the treatment for too long a period. In other cases, where we have commenced with 15 minims doses, no inconvenience has been experienced, and there has been an almost immediate improvement. The old-fashioned idea that patients with chorea got well just as quickly on rest and feeding

and without the administration of drugs is now exploded. The duration of the attack is immensely shortened by giving arsenic.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, February 3rd, 1900.

PRECÆCAL ADENITIS.

At the Société de Chirurgie, M. Gérard said that three times he observed precæcal adenitis, independently of appendicitis, and it appeared to him to be of a tuberculous nature. In one case he perceived in the right iliac fossa a tumour of the volume of a large walnut, in a young girl who had presented twice over signs of appendicitis. In operating, he found to his great surprise that the appendix was absolutely healthy, but there existed in front of the cæcum two large ganglions, one of which appeared to have suppurated. The histological examination confirmed the healthy condition of the appendix; as to the ganglions, they presented a caseous aspect, but the proof of their tuberculous nature was not made. Another patient, age 28, suffered for five or six years from repeated pain in the iliac fossa. The speaker operated thinking to find an appendicitis; in this case also the organ was in the normal condition, but, on the other hand, a ganglion of the size of a walnut was found adherent to the anterior face of the cæcum. He should add that the last patient, as well as the first, was of tuberculous stock.

M. Quénu said that he thought that under the name of para-appendicitis could be designed quite a group of inflammatory processes developed around the terminal portion of the ileum and the cæcum, and comprising the ganglions spoken of by his colleague; of this he had observed several examples. In a patient of seventeen, to whom he had been called a few weeks before a sudden pain in the right iliac fossa, and signs of grave peritonitis appeared following an attack of ordinary grippe. He pronounced the case to be one of appendicitis, and operated the same evening. The appendix was found to be only very slightly congested, but the surface of the cæcum was covered with pseudo-membranous exudations in which were found streptococci and colibacilli.

TREATMENT OF FURUNCULOSIS.

Dr. Gallois communicated the results, quite extraordinary, which he obtained in the treatment of boils and wounds in general by the application of salicylate of methyle. The liquid form of the drug has the advantage of being applicable in wet dressings. Employed in the pure state by rubbing, and on extensive wounds by linen steeped in it and covered by oil silk, salicylate of methyle provokes but the slightest pain. M. Gallois considered it as an excellent antiseptic, preventing the formation of pus and stimulating the granulation of the wound.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, February 3rd, 1900.

At the Free Society of Surgeons last week, Hr. Hernes related a case of

SIMULTANEOUS EXTRA- AND INTRA-UTERINE GRAVIDITY, occurring in a woman of 30, who was admitted into the

Moabit Hospital in September, 1898. She stated that her menses had appeared two months before, and that the evening before admission she had been suddenly seized with spasmodic pains, with loss of breath, and that during the night she had suffered from vomiting and singultus. On admission she was extremely anæmic, very little blood issued from the vagina. There was meteorism and dulness over the dependant parts; the uterus was enlarged, and to the right of it some resistance was felt. The patient recovered from the collapse, and on the 13th, nine days after, laparotomy was performed. A large quantity of clotted blood was found in the abdomen; the right tube was ruptured, and removed along with the ovary. Chorionic villi could be seen on the wall of the tube.

Recovery took place, but some weeks afterwards when the patient was leaving the hospital, the uterus was found still further enlarged. Four weeks later she returned, and complained of vague pregnancy pains, and on examination the suspicion was aroused of a four months' pregnancy, and further examination showed the suspicion to have been well founded. At the end of the period the patient was naturally confined.

ANTIPERISTALSIS.

Hr. Mühsam followed on with a note on the above subject which he had endeavoured to solve experimentally, carrying out to a further extent the experiments of Kirstein. He had cut through the intestine at the border between the duodenum and jejunum, and also at the entrance of the latter into the cæcum, and had attached the cæcal end to the duodenum, and the duodenal end to the cæcal, in order to determine whether such a condition as antiperistalsis really existed. Most of the animals (dogs) died before anything could be ascertained. One dog took nourishment and had a stool before ileus set in, on the twentieth day. Laparotomy was performed, and the symptoms were found due to adhesions. When he separated them gas immediately passed from the upper to the lower part, but the animal soon died. The section showed that of 485 c.m. of intestine, 430 were reversed, so that only 55 retained their original direction. In the material vomited both digested and undigested food was present, showing that peristalsis had still continued in the normal direction. In another dog, operated on in the same way, intussusception had taken place. The remarkable part of this was that the neck of the invaginated part was found directed upwards towards the stomach, also showing that energetic peristalsis had taken place in the normal direction.

In the *Sammlung Klin. Vorträge*, m. 225, Dr. A. Martin discusses the subject of the

LATE CONDITION OF OVIOTOMISED WOMEN.

Ventral hernia is first discussed. Extra-peritoneal treatment of the pedicle, abscess formation in the wound, and drainage all favour the later development of hernia, through the wide and irregular cicatrix that forms. The most important essential for prevention of hernia is the careful adjustment of sutures in layers, instead of suturing in mass, and in support of this the writer adduces the statistics of Winter, Abel, and his own, all showing a distinct diminution in the number of herniæ since the introduction of suturing in layers. An equally valuable factor is union by first intention. But in a certain number of cases, in spite of asepsis and suturing

by layers, hernia will form. He always makes his patients wear a binder, but pads should not be worn. After a year or two the bandage can be replaced by a corset reaching to the pubes with an elastic inlet. Hernia can often be avoided by a carefully regulated diet. He remarks on the fattening treatment now too much in vogue, that often in later years leads to the stretching of cicatrices and the formation of herniæ. As regards the treatment of herniæ, as a rule they cause little disturbance, and as they show but little tendency to cause incarceration, the support of a belt or corset is generally all that is required. In extreme cases operation must be performed, including suturing in layers again. The hernial sac should be removed so thoroughly that the whole of the peritoneal covering is removed.

He then goes on to discuss the effects of removal of the ovaries. Besides the typical symptoms usually described, there are sometimes vicarious bleedings from the nose and rectum, and even from the stomach and lungs. (Your correspondent saw it in one case from the bladder), and in four cases a very troublesome eczema came on. Therapeutically, he recommends scarification of the portio, or leeches or cupping. Regarding the treatment by ovarian substance, he gives an English preparation and in rather small doses, but on the whole his opinion of the treatment is not particularly favourable. At the same time his statistics of the treatment in the natural menopause, or in cases in which the ovaries, whether along with the uterus or not have been removed, the effect was quite satisfactory, as there was a transient improvement in over 50 per cent. of the cases. He suspects there must be a suggestive action, but no control experiments were made with a view of testing the accuracy of the suspicion.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, February 3rd, 1900.

SENILE EPILEPSY.

At the "Medical Club" Redlich brought forward the subject of senile epilepsy, in which he endeavoured to prove that early attacks of epilepsy in life were the prodroma to the final "insult" which was commonly attributed to preceding hæmorrhage or general enfeeblement. To this form of epilepsy belongs cerebral tumours and the presence of cysticerci, of which he recorded two of the latter coming under his own immediate observation.

True senile epilepsy in its symptomatology differs little from that occurring in the young. Its ætiology is usually traced to heredity (which Redlich considers very doubtful), injury to the cranium, alcoholism, acute infectious disease which is rarely met with, and chronic cerebral disease. Redlich here related a case of the latter disease which recently came under his notice. The patient had suffered from psychosis for a long period, till one day, quite suddenly and unexpectedly, he took a fit, which persisted ever afterwards. One of the most important factors in the production of senile epilepsy is undoubtedly arterio-sclerosis which Naunyn has so emphatically asserted as the only cause. Compression of the carotid can hardly be denied as another very potent agent in its production as anæmia of the brain is produced analogous to experi-

ments carried out in animals. This leads us to consider another type of cardiac epilepsy arising from some imperfection of the heart. In contrast to the anæmic theory of epilepsy we often have described a congestive form. It has been asserted from this connection of heart disease and epilepsy, that the former is the cause of the latter which Redlich will not accept, but assumes that two diseases co-exist, and that the treatment of epilepsy should not be bromide of potassium for the fits, but rather some hæmætic or cardiac drug.

In the pathological anatomy of senile epilepsy there were often found a number of lesions, and he described some where he has met with "miliary sclerosis," but he would not speculate on the value of its presence.

To differentiate senile epilepsy, the history will often be found incomplete. In one case of his own there was present left-sided hemiparesis, where subsequently a morbid centre was found in the right hemisphere of the brain. In many other cases he has met with difficulty of speech, being followed by the epileptic fits which often closely resembled progressive paralysis.

In other cases of the same class, amnetic aphasia is often followed by similar attacks. It has been asserted that this epilepsy never proceeds to dementia, but Redlich is unwilling to discuss that hypothesis. Lauterbach thought that a causal connection existed between heart disease and epilepsy, and cited a case of congenital cardiac fitium with dextro-cardia in his 37th year, becoming affected with epileptic fits.

Schlesinger had for many years collected a record of cardiac affections in connection with epilepsy, but failed to find any direct cause and effect.

Redlich thought Lauterbach's case of epilepsy in connection with heart affection too remote for substantiating proof.

WOUNDING THE FACIAL NERVE.

At the Gesellschaft der Aerzte Biehl showed a young man, æt. 22, who in July, 1898, got a stab from a knife on the left ear, wounding the facial nerve and producing paralysis of motion in the movements of the face on the same side. In addition to this there was jerking of the left angle of the mouth with loss of sensibility and vasomotor disturbance, which confirms some of the experiments conducted in animals.

In chewing, the left side of the face became bathed in perspiration extending to the nose and lower jaw, while the right side was perfectly dry. In taking fluid food or when amyl nitrite and pilocarpin were injected this phenomenon was absent.

The Operating Theatres.

GUY'S HOSPITAL.

AMPUTATION THROUGH THE THIGH FOR PERIOSTEAL SARCOMA OF THE UPPER END OF THE TIBIA.—Mr. ARBUTHNOT LANE operated on a boy, æt. 17, who for some months had walked lamely, the knee being kept slightly bent. The patient paid no attention to this condition, but a month ago he struck his knee whilst getting into a cart, and on undressing the same evening he noticed a swelling where he imagined he had been struck. This was seen some time after by a medical man, who aspirated it, and only obtained blood. On admission to the hospital, the knee was slightly flexed owing to a mass in the popliteal space. This was continuous with

a thickening about the head of the tibia, which in front formed a round mass nearly as big as a tangerine orange. The patient having been anaesthetised, the growth was freely exposed, and found to be periosteal in character. The limb was amputated through the thigh just below its centre by circular incisions which divided the skin, muscles and periosteum in different planes. Mr. Lane said a section of the specimen showed that the swelling brought about by the injury was a hæmorrhage into the soft growth.

AMPUTATION THROUGH THE ARM FOR SARCOMA OF THE SKIN OF THE FOREARM.—The same surgeon operated on a man, æt. 48, who some weeks after the receipt of an injury to the forearm noticed a small lump as large as a Brazil nut beneath the skin of the part. He was seen by his medical attendant, who found a mass attached to the deep fascia, and involving the skin. In its immediate vicinity there was a small separate nodule in the skin. These were removed by the doctor who cut very free of the growths; the wound healed most satisfactorily. A short time, however, another nodule was observed in the vicinity of the scar, and later, on his admission to the hospital, several minute nodules could be felt, distributed over a considerable area. The question then arose as to whether, in the face of the very malignant character of the growths, it would be better to remove the skin, fascia, and subjacent muscles, or to afford the patient more security by amputating through the upper arm. The situation having been made perfectly clear to the patient he decided to have his arm amputated without delay. This was done by the circular method through the upper arm just below its centre. Mr. Lane strongly approved of the choice made by the patient, as he considered that the removal of soft parts necessary to effect a complete ablation of the growths would have left the arm almost useless, and might very likely not have obviated recurrence in the skin which would have been left. In both the above operations the principal vessels of the limb, he said, had been exposed and occluded before the muscles were divided transversely so that hardly any blood was lost at the time of the operation.

In both cases recovery was rapid and complete.

GREAT NORTHERN HOSPITAL.

GALL-STONES IMPACTED IN CYSTIC DUCT.—Mr. PETTON BEALE operated on a woman, æt. 40, who had been admitted complaining of intense paroxysmal pain in the right hypochondrium. There was a swelling to be seen, and on examination under an anæsthetic there was little doubt about its being a distended gall-bladder. The onset of the symptoms had been gradual, and there had never been any jaundice. An incision was made over the region of the gall-bladder and parallel to the costal margin about four inches long; in opening the peritoneal cavity the gall-bladder was at once seen very pyriform in shape, measuring about five by three and a half inches; on feeling it, it was found to be full of gall-stones, and two could be distinctly felt in the cystic duct. Cyanide gauze having been closely packed round the gall-bladder, the latter was then pulled out of the wound as far as possible, freely opened and its contents, consisting of inspissated and foul smelling bile, together with seven stones, the largest an inch in diameter, were removed; the organ was freely washed out with lotion. The removal of the stones impacted in the cystic duct was then undertaken; the first, a small one, came away with ease; the second, about $\frac{1}{2}$ ins. in diameter,

gave great trouble, as it appeared to have set up, ulceration of the cystic duct at some time previously, and this had resulted in cicatricial contraction above and below the stone, so that no manipulation by scraping, forceps, &c., could remove the calculus or break it *in situ*, nor could it be grasped by forceps. An incision was therefore made in the wall of the duct over the stone, and the latter removed. This incision was closed as securely as possible, and the wound in the gall-bladder sewn up. The greater part of the abdominal wound was then closed a gauze plug being left at one end. Mr. Beale said that under such circumstances some escape of bile into the general peritoneal cavity could not be avoided. He ventured to state that in nearly every case where the gall-bladder was incised some considerable local intra-peritoneal inflammatory disturbance was found to take place. It was, he thought, as common when the edges of the gall bladder were stitched to the wound as when they were united and the viscous dropped back, and as this was the case, he preferred generally to close the gall-bladder at once without waiting to suture it at a future operation, especially as in the latter procedure one could not be certain of preventing the entrance of bile into the peritoneal cavity.

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“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, FEBRUARY 7, 1900.

THE CHARITY ORGANISATION SOCIETY.

THE policy and methods pursued by the Charity Organisation Society have long since incurred the dislike and distrust of the poor, and have raised misgivings in the minds of not a few thinking philanthropists. Recent events appear to have filled the measure of popular discontent and to have deprived the C. O. S.—as it is familiarly termed—of the sympathies of many of its supporters. As everyone knows, in answer to the appeal for monetary aid for the widows and orphans of British soldiers killed in South Africa, and for the wives and families of

reservists called to the colours the purse strings of the people were freely opened and huge sums of money poured into the relief fund. It is much to be regretted that some wise plan for distribution in common was not determined upon by the various collecting agencies. One of the latter, the Soldiers' and Sailors' Families' Association, called in the aid of the C. O. S. in distributing their monetary help. The result might have been readily foreseen by anyone familiar with the tortuous and dilatory detective policy of the society in question. The pith of the whole movement lay in the speedy supply of enough ready cash to support the wives and families of those who had gone off to fight our battles in a distant country. Funds were ample, needy wives and families were a multitude; to bring the one to the other would seem a simple task to ordinary folk. The Charity Organisation, however, proceeded on their customary lines, their inquiries covering such ground as arrears of rent, moral character, the existence of pawn tickets, possible sources of income, and the circumstances of friends. Pending this inquisition families were left to starve, as attested by numerous letters sent by reservists' wives to the Guardians of Stepney, Greenwich, Poplar, Walworth, St. George's-in-the-East, Deptford, Marylebone, and other Metropolitan districts. Such a burst of indignation followed these disclosures that the services of the society were at once dispersed with, and henceforth it is to be hoped that the kindly generosity of the nation will reach its recipients untainted by the poison of suspicion and the unfor-iveness of past offences. Better a thousand times that a host of undeserving folk should be relieved than that one worthy applicant should be deserted in this time of need. Besides, what have past misdeeds to do with the matter at all—except in the unchristian creed of the C. O. S.? Surely if the husband and the father of the family has shouldered his rifle and gone to the front he has purged himself of a vast deal of offence by freely offering his life to the service of his country! Any man good enough to fight for us deserves our care for those he has left behind him, and no organisation is wanted to rake up reasons for withholding that relief. The underlying policy of the C. O. S. in regulating present relief by past peccadilloes seems to be on the face of it hopelessly and radically wrong. Disease and want are not less in need of assistance because the sufferer has pawned his boots, and not paid up his rent, or has been on some previous occasion convicted of drunkenness. At the same time it may be admitted that the work of the C. O. S. is legitimate so far as it prevents habitual rogues and imposters from preying on the charity of the community. It seems abundantly clear, however, that the inquisitorial methods of the Society have long since carried it outside any such reasonable limit. Here are some facts published by Mr. Thomas Farrow, who has paid a good deal of attention to the subject. In 1897, out of the total income of £19,462 15s. 5d., no less than £10,888 0s. 7d. was swallowed up in salaries, rent, office expenses, publications, district secretaries, agents in training

and money invested abroad. Last year the total income was £16,565 5s. 3d., of which £12,320 15s. 4d. was absorbed in the way mentioned. The balance, £4,245 9s. 11d., being presumably spent on grants and committees, but only the paltry sum of £138 1s. was definitely stated as having been spent in charitable relief. During 1897 applications for relief were made to the Society to the number of 17,814. Of these, 2,021 were withdrawn, presumably owing to the objectionable nature of the Society's investigations. Of the remaining 15,793 assistance was refused to 8,269 persons, who were thus virtually treated as impostors. Of the 7,524 who were assisted, 4,614 received help from "institutions or local agencies," 2,708 were helped by "individuals," and 193 were referred to Board of Guardians. Among other literature the Society issues an expensive journal, and a bulky "Annual Charities' Register and Digest," the production of which must cost a large sum of money. How far the condition of the suffering poor of the United Kingdom is bettered by such an outlay remains to be proved. Certainly at the time of its introduction there was no need for the annual register as the ground was already covered by an excellent publication of a similar kind. On the whole it seems that the C. O. S. itself is in need of a vigorous overhauling as regards both its money expenditure and its methods among the poor. An independent official inquiry would set the mind of the public at rest, and there is no obvious reason why a society professing so high a code of moral ethics should shrink from such a proceeding. Members of the medical profession would welcome any sound machinery for the exclusion of improper applicants for medical relief, but meanwhile they will be inclined to echo the ancient query, "*Quis custodiet ipsos custodes?*"

MEDICAL SOCIETIES AND MEDICAL JOURNALS.

MEDICAL societies and medical journals, viewed as means of generalising information bearing on the progress of medicine, cover very much the same ground and are consequently in the position of rivals. There was a time, before medical journalism had been evolved from chaos, when the medical society afforded practitioners virtually the only opportunity of comparing notes and inviting criticism, a time which, archæologically, occupied approximately the same place in history as the systematic lecture does, or did, in medical education. When books were rare and costly oral teaching enabled the diligent student to compile his own notes, but since teaching has been systematised in books these selfsame lectures have lost their *raison d'être*, though they still survive in virtue of that uncompromising conservatism which characterises pedagogues of every denomination. In the same way the necessity for medical societies has to some extent disappeared because the object for which they exist is better filled by publication in the medical journals. A lengthy contribution embodying the concrete results of much labour and research requires sustained attention and

concentrated thought before it can be assimilated, and these are only possible on condition that opportunities are afforded for its perusal. It follows that societies have been driven to take steps to enable intending speakers to obtain communication of the paper in advance, either by anticipating publication in their *Transactions* or by furnishing printed abstracts. Obviously a much simpler plan would be to publish the paper beforehand in the medical journals. This would economise time in that it would be unnecessary to devote half the evening to the reading of the paper, while, on the other hand, those who are interested in the particular subject would have ample opportunity of thinking the matter over, and of preparing their own observations. We should in this way avoid the *fiasco* which is so frequently the lot of the best description of papers; indeed, so far as discussion is concerned, the best papers offer the least scope therefor, simply because, if replete with facts and observations and closely thought out, no one is ready, on the spur of the moment, with remarks worthy of the occasion. Not very long since most medical societies were very jealous of their proprietary rights in the papers read at their meetings, and although this rule has of late years been somewhat relaxed, the majority still restrict the right of publication to their own "*Transactions*." This, from all points of view, is a foolish and selfish policy, for it virtually confines the writer of the paper to the limited publicity of his fellow-members. A fabulous amount of money is wasted year after year in the publication of expensively got-up volumes which are immediately relegated to the shelves of the library, so that the object aimed at, which we suppose is the diffusion of knowledge, is to a great extent frustrated. If this rule were abrogated a much larger publicity would be gained in the medical press without the expense entailed by these bulky "*Transactions*," and authors would cease to feel tempted to reserve their best work for the much larger public commanded by the medical journals in lieu of interring it in the quasi-obscure of the "*Proceedings*." Another not inconsiderable advantage would be that much more space could be devoted to the discussions, which are often more interesting and instructive than the paper on which they are based. After all, the reflections and conclusions of an author only constitute an *ex parte* statement, and their value is only established by discussion, in the course of which omissions are remedied, doubtful points elucidated or dismissed, and illogical conclusions dissected and adjusted. For some years past the societies have experienced steadily increasing difficulty in getting men to come forward with papers, in consequence of the temptation to seek publicity in the medical journals, and unless they modify their rules and adapt themselves to the new order of things this difficulty cannot fail to go on increasing. The multiplicity of medical societies is another source of trouble, yet we look in vain for any indication of a desire to join hands. The death of Sir Andrew Clark cut short a movement which

might conceivably have culminated in a federation of existing societies—a consummation devoutly to be wished in the interests of the societies themselves. As a means of disseminating technical knowledge, medical societies have to a great extent been superseded by the medical press, but they have a special rôle of usefulness which will ensure their survival in spite of adverse circumstances. They afford practically the only opportunity for kindred spirits to come into contact, and they tend to break down the isolation which is fostered by the ordinary routine work of practice. Since this, after all, is their special sphere, it is a matter for surprise that those who are responsible for their management do not do more to cultivate the social element, an idea which the genial Sir Edward Sieveking and Mr. Timothy Holmes, as past Presidents of the Royal Medical and Chirurgical Society, did their best to inculcate. Another department in which the societies may be expected to achieve popularity is the clinical evening. The Royal Medical and Chirurgical Society is almost alone in not having introduced this “great attraction.” All societies profess the desire to enlist the general practitioner; but he, busy man, has little taste for the more recondite subjects which constitute the *pieces de résistance* of the proceedings, while he displays a lively interest in the practical knowledge to be gained by the inspection of a series of “living specimens.” In future, then, the success of our medical societies will probably be in proportion to the degree in which they cultivate the social and practical sides of medicine, leaving the more highly technical subjects to be dealt with in the medical journals, a medium in every respect more suitable for their consideration.

WOMEN AND WORKING MEN MEMBERS OF HOSPITAL BOARDS.

GLASGOW is at present concerned over the question whether the Board of Management of her Royal Infirmary shall not be enlarged, and at the same time made available for the admission of women and working men representatives, elected by the general body of qualified contributors to the Hospital funds. As the number of managers in this instance is at present only ten, a nominal increase may not be undesirable, especially as a scheme of reconstruction and extension is in progress. At a general meeting of contributors, held last week, a unanimous resolution was adopted, with the agreement of the present managers, to the effect that women and working men should, as soon as possible, be rendered eligible for election. As the small size of the Board, as now constituted, appeared to its members to negative any idea of substituting ladies or working men for any of the present number, the only plan which recommended itself to the meeting was to agree to wait until the charter of incorporation had been altered, so as to allow of an increase in this number. This necessary alteration is to be made as soon as possible. A few years ago the Royal

Infirmary of Edinburgh admitted two ladies on its Board despite a considerable amount of opposition to such an action; the result has been most satisfactory. The Western Infirmary of Glasgow has had a similar experience. There is a great difference between a Board of ladies, with perhaps a man or two, and one consisting chiefly of men, but with one or two ladies on it. A female leaven is often beneficial and desirable in the management loaf; a female loaf, even with a male leaven, is generally disturbing. It has been often said that when a man applies himself to do any kind of work usually regarded as appertaining to womankind, he does it just as well, or even better, than the gentler sex; but it stands to reason that men who conduct the affairs of a large hospital, with all the manifold details, may often be advised by woman and guided in the proper paths, concerning many matters more familiarly known to her than to them. When details as to clothing, food, as regards female servants or nurses, come up before the Board for supervision, feminine experience is of value; while communications between the Board and the female officials of the house are rendered more facile and satisfactory. The advantage to be gained by the compulsory inclusion of working men in a Board seems not to be so clear. The conduct of the affairs of any large institution in a proper manner is best carried out by those who have had former experience in the management of large undertakings, be they commercial or professional. The matters which come up for discussion require the broadest handling. Between the patients, the officials, the contributors, and the conflicting interests (usually supposititious) the medical staff have to be impartially considered. It is open to question whether the demand for working men representatives is not based upon the popular opinion that hospitals only exist for the immediate benefit of those admitted, not for the furtherance of medical science and skill, or for the training of those who will hereafter be called upon to treat them or their children. It is wonderful how widespread the idea is among the working classes that hospital treatment is a right, not a charity, although the hospital be supported by voluntary contributions. Regarded in this light the patients naturally conceive that any use made of their symptoms for the furtherance of medical knowledge, or for the education of their future medical attendants, savours of injustice; forgetting that, without students, the members of the visiting staff would not be drawn from the highest ranks of the profession, the hospital probably would not be able to support so many beds, and the treatment given them would not be synonymous with the best obtainable even by the rich. The medical staff give their services gratis in return for experience gained; the patients should be ready to meet them half-way; recognising the good done to the community by the training of future doctors and by the opportunities afforded to the staff for the discovery of the true nature of disease, and the means best adapted to cure it.

Notes on Current Topics.

The Dublin Conjoint Examinations.

THE report of the results of the Autumn examinations has just been presented by the Conjoint Committee. It deals with the examinations, which commenced on October 2nd, and we do not observe that it contains, as it ought, an apology for the delay of nearly three months in presenting it. A fortnight ought to be abundantly sufficient time to compile an analysis of passes and rejections, and to have it printed, and we submit that the system of holding back the figures is altogether unnecessary and objectionable. The total number of candidates examined shows a serious falling off from the number for the similar examination of 1898:—129 for 1899 as against 152 the previous year. The rejection percentage varied between 38·5 for the first examination to 62·5 for the third examination, and the average of all the four examinations was 45·8. For the first examination we note that every candidate who presented himself in anatomy passed, and the Committee expresses the opinion that the standard of answering in that subject is not sufficiently high. At the second examination the "mortality" was very great, the percentage of rejections being 62·5, a result which manifestly arose from the examiners in physiology having, as usual, run riot in their marking. For 28 candidates passed 23 were rejected by them. For the third and fourth examinations the figures are almost equally discouraging. In medicine, for 24 passed 18 were rejected, and in surgery, for 19 passed 14 were rejected. The Committee favours us with the stereotyped statement that "the various portions of the examinations were, in general, satisfactorily carried out and were conducted strictly in accordance with the regulations"—an opinion which certainly is not shared by either teachers or students as regards the physiology and histology subjects. The attention of the Committee of Management has been more than once called to this matter by the College of Surgeons, but, so far as we know without eliciting any more satisfying explanation than the repetition of this platitude. The preliminary examinations held by the same Committee show a more satisfactory result, although the number of candidates (101) was below that of last year (117). The entrants seem, however, to have been a better class than in 1898 for the rejection percentage was only 47·5 against 53·5. These examinations are now conducted by high class educationalists unconnected with the medical profession or with school or collegiate interests. It would be well if as much could be said of the University examinations, for whose benefit the General Medical Council is seeking to extinguish the Dublin Preliminary.

A PASTEUR Institute was opened in Lyons at the beginning of the year. This makes the eighteenth institution of the kind in France.

The Death-rate of Liverpool.

THE City Council of Liverpool are disturbed at the high mortality-rate which is now prevalent in the town, and there is reason for their anxiety, inasmuch as the death-rate is 50 per cent. higher than was the case at the corresponding period of last year. Investigation into the various causes of death shows that there was no special malady answerable for this great increase. Although an influenza epidemic had claimed many victims, the returns nevertheless indicated that only one-fifth of the increase could be attributed to this disease. It has, therefore, been pertinently asked, if only this small proportion of the increase could be assigned to influenza, how was the remaining percentage of the augmented death-rate to be accounted for? No satisfactory reply to this query has, so far, been forthcoming; nevertheless it would be interesting to have some information upon the subject, for it is generally admitted that the Liverpool Corporation spare no expense in perfecting the sanitary condition of the town, and, moreover, they have an excellent medical officer of health in Dr. Hope. Some attempt has been made to explain the high mortality-rate by attributing it in some degree to the particular class of people who make Liverpool their headquarters. It has been said that the town is the resort of the residuum of the working classes, who take shelter within its confines when they cannot obtain work elsewhere. But it does not appear that the death-rate is especially high among the classes in question, and therefore this explanation does not seem to us to be adequate, at all events so far as Liverpool is concerned. Whatever, then, may be the causes of the high mortality-rate in Liverpool, it is clear that some faults must exist in the sanitation of the town which require remedying; however, it is not to be supposed that the Liverpool Corporation will fail in their duty to make good the defects as soon as they have been shown what these defects are.

Colour Blindness in Negroes.

It is commonly believed that impaired colour sense is less frequent among the black than among the white races, and in support thereof, in a recent examination of two thousand negroes employed upon a railway, Dr. Allport, of Chicago, was able to show that no case of the kind was discovered. But in a limited number of negroes examined by Dr. Joy Jeffries two per cent. of colour blindness was found. Again, Dr. Burnett, as the result of the examination of three thousand negro school children, showed that about one-and-a-half per cent. of the boys, and about one-tenth per cent. of the girls, had impairment of the colour vision. The relative frequency of defective colour sight between white and black races is not without interest in connection with the assertion that within historical times there has been an increase in the acuity of colour perception. It has been argued, however, that this theory is not borne out, in view of the infrequency of any defect in this regard among negroes. In other words, if good colour perception be acquired as the result of prolonged civilisation, it is

difficult to see how this faculty should be so well developed in a race like negroes, whose ancestry could not be included among the civilised races of the world. Possibly, however, the development of the colour sense among negroes has been acquired as the result of their natural environment. Just in the same way as the special senses are very largely developed in certain nomadic Indian tribes, so it may be that the possession of good colour vision was found to be a necessary adjunct to the habits of the negro race.

Veterinarians and Surgeons.

In the statement issued by the Government during the past week bearing on the organisation of the Yeomanry Corps for service in South Africa there is one point which cannot fail to attract the attention of medical men, viz., the emoluments offered to the surgeons in charge of that force is put at the not exorbitant figure of £200 per annum, whereas the remuneration provided for the veterinarians amounts to £250. Why this difference? Is it that there is less competition in that department of medical practice, or is it simply because the services of veterinary surgeons are valued more highly than those who merely tend the wounded and sick soldiers? The matter is so extraordinary that we shall be grateful to any member of Parliament who will make it the subject of a question in the House.

The Fatalities of Sport.

THE occurrence of a second fatal mishap in connection with a boxing match within a few months of the first suggests the propriety of revising the rules under which this time-honoured sport is at present carried on. Unfortunate as are these occurrences we cannot admit that they of themselves justify an indictment of boxing. Similar accidents are regrettably frequent in the cricket field and as the result of collisions at football, indeed every sport entailing violent exercise claims its victims. We do not quite grasp the reason for the difference in the treatment of these cases by the police. We have never heard of a footballer being brought before the magistrate on a charge of homicide by imprudence, and unless the inquest reveals special circumstances we fail to see what good can accrue from prosecuting the boxer who has been unfortunate enough to kill his adversary. It is impossible to regard these proceedings as anything else than a judicial farce, because no British jury could be hectored or cajoled into finding the accused guilty of anything calling for punishment. Nevertheless, since experience has proved the possibility of administering deadly blows with the light gloves in use at boxing matches, the managers of the National Sporting Club will be well advised in revising their rules in regard to this point, if only to disarm hostile criticism. At the same time no amount of padding will ever completely eliminate the risk of a fractured skull or a broken or dislocated neck, since, apart from the force of the impact, there must always remain the danger of violent collision with the floor. A certain section

of the public view this particular sport with frank misgiving on account of its resemblance to real fighting, a display of brute force which they find aesthetically objectionable. but fencing is another instance of the same thing, and fatal accidents are not unknown in the *salle d'armes* as the result of the defensive button dropping off unperceived. We must accept these risks if we are to derive the benefit of such sports in developing the body, and in this respect they stand on the same footing as the loss of life which is associated with every considerable industrial undertaking.

What is a Common Lodging House?

The judges of the Queen's Bench Division had before them last week the case of the Emigrants' and Working Men's Homes Association, on an appeal by the London County Council against the refusal of a metropolitan police magistrate to find that a particular building ought to be registered as a common lodging house. They arrived at the decision that the building in question could not be distinguished from the Salvation Army shelters which had previously been assimilated to common lodging houses, and they consequently decided that the law must apply to them as such. Any other view would have been very regrettable from the point of view of public hygiene. The principal object of the regulations affecting these buildings is to protect the public against the spread of infectious disease and to prevent overcrowding, and, if such precautions are necessary in the one case they must logically be applied to every institution of a similar kind. The fact of their being carried on for a profit or on purely charitable lines is not, strictly speaking, *ad rem*, for the recipients of charitable assistance are as much entitled to protection as any other class of the population. Moreover, we do not understand exactly why the managers of these institutions so obstinately resist the moderate amount of interference which the regulations comport. It may entail some trifling additional expense, but in view of the advantages to the inmates and to the public of the enforcement of certain elementary sanitary precautions, their opposition savours of imbecility. We take it that this decision settles this vexed question once and for all, so that in future philanthropists who contemplate the organisation of these shelters will do so with these regulations clearly before them.

Glaucoma following the Instillation of a Mydriatic.

THE case of glaucoma recorded at the last meeting of the Ophthalmological Society as having occurred after an instillation of a four-grain solution of homatrophine, again emphasises the risks associated with the use of mydriatics in elderly persons. The golden rule is to avoid as much as possible the use of such drugs after patients have reached the age of thirty. But where dilatation of the pupil is essential to a complete examination of an eye, it is always best in middle-aged people to neutralise the effects of a mydriatic afterwards by means of eserine. This is

really the only means by which accidents of the kind can be avoided, for it is not possible in every case to say whether sudden increased tension will not ensue after a mydriatic has been used. The importance of the matter is that advancing hypermetropia is commonly a premonitory symptom of glaucoma, and it is in these cases that the danger especially lies; an instillation of a mydriatic under such circumstances might just be sufficient to upset the balance of the tension, leading to the rapid development of the disease. But there is another aspect of the matter, which also impels caution in these cases. Patients are naturally disposed to remember that until the "doctor" ordered some drops for their eyes their sight was good, but as soon as the drops were used the sight began to fail, acute pain to supervene, and ultimately the vision became entirely lost. Then in consequence reputations are apt to suffer injury, for the facts are indisputable and there is no possibility of explaining them away. Such cases belong to the "calamities of surgery," since it is not always possible, owing to the negligence of the patients and other causes, for the mischief done to be made good.

The Pharmaceutical Preliminary Examination.

It is officially announced that the forthcoming preliminary examination of the Pharmaceutical Society of England will be the last to be held, and its place will subsequently be taken by scholastic examinations, conducted by universities and other examining bodies in the United Kingdom. The last examination will take place on July 10th.

Is the Plague in England?

It has been suggested by a correspondent of THE MEDICAL PRESS AND CIRCULAR that the plague may be really in our midst in an unsuspected form. While the facts on which this surmise is founded are as yet too scanty to warrant any definite conclusion, they are nevertheless sufficient to demand scientific investigation. Briefly, some six or eight months ago there appeared at Southampton a disease which attacked dogs, and proved so fatal and infectious that in a short space of time the town was practically cleared of its canine population. Since then the disease, which appears to be of a highly specific nature, has spread slowly but surely over many parts of the United Kingdom. Deaths from this epidemic are occurring at the present time in London, and veterinary surgeons are now everywhere alert as to its occurrence. The points suggestive of plague are the invasion of a seaport town, where dogs might easily become infected through ship rats, and the fatal nature and the high degree of infectiousness of the malady. On the other hand, it is hardly likely that if plague had really attacked so widely domesticated an animal, that the contagion would not quickly have been communicated to man. On the whole, the theory of plague, although ingenious and even remotely possible, cannot be regarded as probable. At the same time it would be of great

interest to learn from the veterinary profession what are the facts about this canine zymotic, and whether any scientific investigation has been made as to the nature, both chemically and bacteriologically. There can be no doubt that the communicable diseases of the lower animals have an enormous influence upon the present prevalence and the future prevention of preventible diseases.

Should Hospital Post-Mortems be Compulsory?

THE legal position of hospital medical officers with regard to post-mortem examinations is somewhat complicated. There is nothing illegal in such an examination provided the rights of other persons and of the coroner be not interfered with. When an inquest is to be held the post-mortem may be ordered by the coroner, and no one may anticipate that decision. In other cases the medical officer may safely proceed to make a *sectio cadaveris* if he have the consent of the friends of the deceased. From a strictly legal point of view the possession of the body is vested in the executors or administrators, but in practice that priority is waived in favour of relatives. Where a post-mortem is performed on a body awaiting inquest or without the consent of relatives the step is taken entirely at the risk of the person who performs it. In many medical charities it is made a condition of admission that the authorities reserve the right of holding a post-mortem examination in case of death. In the Poor-law infirmaries the consent of relatives is an invariable condition. There can be no doubt that by refusal an immense amount of valuable clinical material is lost to the medical profession. So far as one can see, there is no particular reason why the legislature should not empower the medical officers of Poor-law infirmaries to conduct such examinations wherever they may deem such a proceeding desirable. It is hardly needful to remark that any contract entered upon by a man as to the disposal of his body after death is invalid at law, so that a man who gives directions that he shall be dissected or burnt cannot be sure that his wishes will be carried out.

The Prophylaxis of Syphilis.

DR. CHARLES DRYSDALE calls attention to Professor Fournier's recently expressed opinion that systematic inspection of prostitutes as a means of checking the spread of syphilis is a failure. The Professor concludes that the "English" system of treating such cases in hospital is in every respect preferable. The weak point in the argument is that there is no English system of the kind, if we except the Lock Hospital, which can reach but the fringe of infection. It is indeed a lamentable thing that in practically all English hospitals it is the rule not to admit cases of primary syphilis. It has often been our experience that a girl, on being warned of the consequences to others of her diseased condition, has forthwith expressed her willingness to enter the hospital for treatment, only to be met with the reply that such cases were not eligible. Under

these circumstances their only resource is to continue to ply their wretched calling. The fact is that the lay governors of hospitals are largely recruited from among ministers of religion who evince an indisposition to do anything which may have for consequence to lessen the risks run by the incontinent. They are deaf to the argument that the innocent have in great measure to bear the brunt of the erring one's misconduct and they maintain the veto. If we were really serious in the wish to do our best to stamp out this hideous disease every general hospital would have its special ward for syphilis. The proportion of diseased prostitutes who would refuse to avail themselves of the opportunity for treatment would be small indeed, and this system of voluntary notification would probably do more lasting good than any detective and punitive system yet suggested.

Public Lavatory Accommodation.

DURING recent years a great deal has been done in the way of increased public lavatory accommodation in almost every large town in the United Kingdom. No doubt much of the zeal may be traced to the discovery by local authorities that a modern, well-fitted establishment was a sound commercial investment. Another reason was doubtless due to the construction of such places underground, in space that would otherwise have been valueless to the public. Perhaps one of the most sensible developments has been the provision of accommodation for both sexes, although there can be no doubt whatever that the wants of women in that direction are still inadequately met all over the country. The crowded condition of public lavatories in our great towns, especially in the dinner hour and when work is over, makes one wonder what must have been the state of affairs before modern extensions had taken place. Another aspect of the case is the need of increased free accommodation, which is clearly enough demanded in poor districts. Indeed, the recognition of such a requirement should form one of the earliest efforts of an enlightened public health administration. Curiously enough, the important question has never been seriously taken in hand by the London County Council, but some day we may expect that body to turn some of its ubiquitous energies in this much-needed direction.

Amateur Plumbing.

IT is hardly credible what gross travesties of sanitary plumbing are often introduced into good-class houses by builders and workmen who are not acquainted with the principles of practical sanitation. The worst cases are to be found in large country houses, where repairs or reconstruction have been confided to some local wiseacre, who may be shrewd enough in many other ways to have established a reputation as jack-of-all-trades. Woe betide the household whose sanitary safety is confided to such a man. The results are often written large in the sore throats, the anæmia, the chronic ill-health of inmates, or more acutely in outbreaks of diphtheria,

diarrhœa, or typhoid fever among the inmates. The unfortunate owner of the house, who has probably paid a large sum to have everything "thoroughly overhauled," and brought up to the best modern requirements, at length, has his suspicions aroused, perhaps on the prompting of his medical attendant, and thereupon consults an expert. Then comes the disillusion as each detail of defective plumbing, and of sanitary ignorance is laid bare in the fool's paradise. Water cisterns are found with overflows opening into closet pipes, and affording a supply in common to closet and to drinking service; unventilated and leaking soil pipes, leading without traps into outside drains; sewer ventilators opening close to windows; fixed washing basins with discharge pipes passing untrapped into soil pipes; drain pipes with loose joints running under the house, and so on *ad infinitum*. The worst feature is, when, as sometimes happens, this criminally bad workmanship is carried out under the direction of an architect. The truth of the matter is that no amount of natural cleverness can replace systematic practical training in sanitary matters.

The New Registrar-General.

THE appointment of Mr. Reginald Macleod, C.B., as Registrar-General, in the place of Sir Brydges Henniker, who retires under the age limit, has been approved by the Queen, so that one more opportunity has been lost of nominating a medical man to this important office. In a recent number we drew attention to the advantages which would attend the presence of a medical man at the head of this department. We pointed out that a medical training is indispensable for the proper appreciation of the value of many of the items of which statistics are made up. As matters stand at present, the scientific importance of these statistics is diminished in consequence of the impossibility in many cases of ensuring that the units of comparison are strictly comparable, and this is especially the case in regard to the certificates of the cause of death. It seems to be assumed in Government circles that a professional training is inconsistent with business and administrative aptitudes, an assumption which experience has shown to be devoid of foundation.

Filtration and Health.

THE importance of the water supply in respect of the incidence of such diseases as typhoid fever is too well known for it to be necessary to insist thereon but, as sundry painful experiences of recent date have shown, the lesson is one which is not yet fully appreciated. The last report of the Massachusetts Board of Health comprises a statement which affords an excellent object lesson. In the city of Lawrence the mortality from enteric fever averaged between 47 and 69, falling to 39 in 1893. In the latter half of that year filtration beds were constructed and the mortality at once fell to 24. The diminution has been maintained ever since, the number of deaths in 1898 not exceeding 8, equal to 1.39 per 10,000 of inhabitants.

Gonorrhœa a Cure for Inebriety.

A CORRESPONDENT writes:—One of the best cures I am acquainted with for habitual excessive indulgence in alcoholic beverages is the gonococcus. This is not a serum treatment because, for the purpose in view, the effects of the organism must wreak themselves on the urethra. I have, over and over again, failed to induce patients with this particular weakness to control their appetite for alcohol. Promises of reform were made only to be broken. Then it has happened that they contracted gonorrhœa, and forthwith, without any pressure, for three long months at least, they have foregone their tippie, and have recovered the strength of will which they had lost. I could point to a number of cases in which the drunkard's progress has been summarily arrested by an intercurrent attack of gonorrhœa with the most satisfactory results in respect of his after life. It is open to question whether, in refractory cases this treatment might not offer an alternative to seclusion in a home for inebriates.

The Hull Small-Pox Bill.

THE inhabitants of Hull are now in a position to appreciate the importance of taking steps to prevent such things as epidemics of small-pox. The recent outbreak, which is now approaching extinction, has cost the borough no less than £21,056, a sum which will entail additional rates to the tune of eightpence in the pound. But it must be borne in mind that this sum, large though it be, does not even approximately represent the financial loss to the citizens of the stricken town. To it must be added the loss of hundreds of pounds sterling which the epidemic must have caused in business, to say nothing of the loss of life and health which such a visitation entails. We trust the lesson will not be thrown away on the authorities of other towns and cities where the protective value of vaccination has in the past been deliberately rejected.

Quack Medicine Advertisements.

THE Chairman of the Edinburgh Public Health Committee has recently made some strong, but not at all too strong, observations on this subject. "There were few more discreditable instances of man's inhumanity to man than the professions made by vendors of various kinds of medicines to heal troubles which they could not possibly alleviate in the slightest degree. Poor people were not merely swindled by these medicines, but in many instances, after using them, were brought to a worse condition than before, and sometimes even their lives were endangered. So-called religious papers, and papers which professed to exist for the purpose of promoting the social well-being of the people, he found to be the worst offenders by the publicity they gave to quack medicines. Some of the medicines offered as priceless were absolutely worthless, and worse than worthless. Pills had been found to be made of ginger, soup, and aloes of the coarsest description. The ginger and aloes were held together by the worst of soap, and out of that concoction was made a box of

pills which were said to be a cure for almost every malady that afflicted the human being. It was said that some papers could not live without advertisements of this description, but such papers ought rather to refuse to exist than be means of not only imposing on people, but helping others to make homicides of themselves."

"Lennox" of the "Echo."

ALFRED MELLETT PEIRSON, otherwise known as "Lennox," has had to "apologise fully, freely, and unreservedly," for publishing a libel against Dr. James Griffin, of Banbury. The use by this individual of the pseudonym "Lennox" has been the occasion of considerable annoyance to a well-known member of the profession practising aural surgery. But in view of the fact that in affidavit Peirson gives his first names as those of Alfred Mellett it is matter for further comment that his name is to be found in three different places in Kelly's Post-office Directory as one of the two aurists and again as an aural specialist, wherein the name is given Lennox Peirson, as if the first were not a pseudonym but his Christian name.

The Coming Army Medical Competitive.

It is stated that the entries for the coming competitive, for which thirty vacancies were advertised, only number twenty-five. This is a very serious conditions of affairs, if "my military advisers" could only see it, because the absolute necessities of the Service demand a reinforcement of the Royal Medical Corps by at least a hundred officers. We are, however, not so sanguine as to hope that Pall Mall or Whitehall will realise this fact.

THE dangerous use of some of the so-called "pick-me-ups," was exemplified a few days ago in the case of a medical practitioner at Sheffield. He had hurriedly swallowed an overdose of one containing strychnine, and was shortly afterwards found violently convulsed, death supervening in a few minutes.

PERSONAL.

DR. W. PASTEUR, F.R.C.P. Lond., Assistant Physician and Dean of the Medical School, Middlesex Hospital, has been elected physician to the hospital.

PROFESSOR CLIFFORD ALBUTT has been elected as the next Harveian Orator, Dr. Archibald Garrod, as Bradshaw Lecturer, and Dr. John Sykes as Milroy Lecturer at the Royal College of Physicians, London.

SIR PHILIP SMYLY has been re-elected by the Council of the Royal College of Surgeons as representative of the College in the General Medical Council for one year from this date.

HER Royal Highness Princess Beatrice will to-day open the new wings of the Royal South Hants Infirmary. The sanction of the Queen is to be asked for the change of designation from Royal Infirmary to Royal Hospital.

THE representative of the English Local Government Board appointed to serve on the Commission of Inquiry as to Dublin Sanitation is Dr. Theodore Thompson, one of the medical inspectors under that Board. The roll of commissioners is now complete.

MR. LENNOX BROWNE has retired from the active staff of the Central London Throat and Ear Hospital, but will continue to be identified with the institution as consulting surgeon. His colleagues on the committee and medical staff have, in the past week, presented him with an illuminated address recording "their high appreciation of the energy, devotion, and skill which he has exercised on behalf the institution since its foundation in 1874," accompanying the address with a gift of old English furniture for use in his country house.

ON Thursday last, Sir William Thomson left Dublin for Africa, and he was followed on Friday by the other officers and men of the Iveagh Field Hospital, who had been formally inspected by the Officer commanding the Dublin garrison, on the previous day. The send-off of both Sir William Thomson and his force was most enthusiastic, the railway station and the quays being crowded on both occasions by a cheering mass of the public and of the profession. Sir William has proceeded by the ordinary mail steamer from Southampton in order that he may be at Cape Town some days before his expedition arrives. They were to leave London in a day or two.

LIEUTENANT-COLONEL SLOGGETT, R.A.M.C., who has accepted the appointment of Military-Director-in-Chief and Principal Medical Officer to the Imperial Yeomanry Hospital, and has, at the request of the committee, been specially recalled by the War Office authorities from Egypt, has been twice specially promoted for distinguished service in the field. It is related of him that at the battle of Khartum he was dangerously wounded; indeed his body had been placed with others for burial, when by a happy incident someone noticed a slight sign of life. The ball entered his breast and came out under the shoulder blade, and his recovery was recorded as one of the most marvellous in the annals of surgery.

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

WORKMEN'S COMPENSATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your leading article of last week on this subject opens up a very important but withal delicate question. Evidently, unless the Act is worded so as expressly to exclude the secondary consequences of an injury, these must be held to form an integral part of the damage. It has over and over again been held that a policy of insurance against accident covers blood poisoning *inter alia*, and it is not obvious why workmen's compensation should be calculated on a different basis.

The assertion that only broken-down or otherwise unhealthy individuals fall victims to blood-poisoning is a pure assumption without scientific support. If the writer of the article were inoculated with an active culture of some pyogenic organism, the chances are that, whatever his state of health may be, he would

suffer severely, and this experiment is one which is constantly being enacted in daily life. Such an inoculation, when the result of an accident, is as "accidental" as a broken leg, and once again there is no obvious reason why it should be regarded as anything different.

At the same time there may be special circumstances which might conceivably exclude the workman from the benefits of the Act. If, for instance, he accidentally scratched his hand with his scarf-pin while at work and contracted blood poisoning, that might be construed as occurring outside his calling, but a carpenter who, in hauling planks, runs a splinter into his finger, is very legitimately entitled to compensation.

Employers may be trusted to take care of themselves, indeed they have already done so by the aid of insurance companies, moreover they have no status from a medical point of view.

I am, Sir, yours truly,

M. O. H.

MINUTE DISPENSING.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In reference to the statements and correspondence recently appearing in your journal, and where you state that pharmacists are incompetent to compound prescriptions containing minute quantities of potent drugs, I am requested by the Dublin Chemists' Federation to forward to you the following resolution passed at the last meeting on the 26th ult. :—

"The Dublin Chemists' Federation protests against the statement made by the MEDICAL PRESS & CIRCULAR that pharmacists are incapable of dispensing minute doses of potent drugs. On the contrary, they confidently assert that chemists can compound such more accurately than wholesale pill and tablet makers. Such prescriptions as those referred to are the daily work of ordinary pharmacists."

I am, Sir, yours truly,

J. SMITH, Hon. Sec.

Dublin Chemists' Federation, Dublin,
February 1st, 1900.

Our observations on this subject have been entirely misinterpreted, and we regret to observe that they seem to have given offence to the chemists. What we did say was that "We should like to see the practitioner who would venture to hand to a patient from the country a prescription for half a dozen pills containing, each of them, say, a thirteenth of a grain of strychnine, or phosphorus, or strophanthin, or cocaine, or atropine. The tablet makers can grind a drachm or an ounce of strychnia into a multitude of tablets, but the individual dispenser cannot be certain of effecting the same subdivision for half-a-dozen pills." We do not doubt that there are many skilled and punctiliously careful compounders who could do so, but the provincial prescriber can rarely send his patient to them, and we repeat that it would be very risky to entrust such minute dispensing to the average country chemist or his shop assistant.

The Medical Officer Frauds.

A MAN called Edward Hopwood was recently sentenced at Birmingham Quarter Sessions to fifteen months' imprisonment for attempting to obtain £100 from Dr. M. Duncan Laurie. Hopwood represented that he was commissioned by an American Insurance Company to appoint medical officers in the chief towns of Great Britain at a salary of £100 on their agreeing to take shares for £100. He offered Dr. Laurie the appointment, and asked for £100 down, but the doctor was suspicious, and the police were communicated with, the result being that it was found that the company did not exist.

Obituary.

SIR THOMAS GRAINGER STEWART, M.D. EDIN.,
M.D. DUBLIN, AND R.U.I. (*honoris causa*); F.R.C.P. EDIN.,
LL.D., F.R.S.E., HON. F.R.C.P.I.

We regret to announce the death, on the morning of Saturday last, of Sir Thomas Grainger Stewart, Professor of Practice of Physic and of Clinical Medicine in the University of Edinburgh. Last summer we had occasion to refer to the fact of his serious illness, and again this winter to his slow and doubtful convalescence; but his death occurred unexpectedly at the end, for he had improved so much a short time before as to be able to take carriage exercise. The actual cause of death appears to have been simple failure of the heart, the sequel to a somewhat prolonged affection of that organ, originally, we believe, of influenzal origin.

Sir Thomas Grainger Stewart at the time of his death was 63 years of age, having been born in 1837 in Edinburgh. Educated first at the Edinburgh High School, he next studied medicine at the University of his native city, and took his degree when 21. After a stay in Germany, spent in study in Berlin, Prague, and Vienna, he was appointed house physician in the Royal Infirmary, Edinburgh, shortly to be advanced to the post of pathologist. While occupying this position he engaged in work upon renal pathology, which led later to the publication of his well-known treatise upon "Bright's Disease of the Kidneys."

At this time Dr. Grainger Stewart lectured in the Extra-mural School of Medicine on Pathology. Later he was appointed one of the assistant physicians to the Infirmary, and in 1873 commenced to lecture on medicine in the Extra-mural School, only to be transferred in the same year to fill the vacancy caused by the death of Professor Laycock in the Chair of Practice of Physic of the University, a chair which he filled up to the time of his death. Many honours were conferred on him in after life. He was made one of the Physicians in Ordinary to the Queen in Scotland; Aberdeen University awarded him the degree of LL.D.; Dublin gave him two M.D. degrees and a Fellowship, *honoris causa*, as did Philadelphia; his own college in Edinburgh elected him its President some few years ago; while in 1898 he filled the post of annual president of the British Medical Association at its Edinburgh meeting.

Sir Thomas Grainger Stewart as a professor was very successful. He lectured clearly, pleasantly and instructively. To him had been given the gift of words, and felicitous expression. No need for him to pause in search of appropriate terms in which to clothe his meaning. His words exactly and happily expressed what his mind conceived. Interesting his lectures always were, frequently enlivened with touches of a pawky Scotch humour, of which he had no small share. His gift of language stood him in good stead when called upon to deliver an address, and made him one of the best of after-dinner speakers. To these were added a fine figure and a commanding presence.

His chief contributions to medical literature comprise "A Practical Treatise upon Bright's Diseases of the Kidney," of which a second edition appeared in 1871; "Clinical Lectures upon Important Symptoms: 1. Giddiness (two editions), 2. Albuminuria;" "An Introduction to Diseases of the Nervous System;" along with a number of shorter communications and addresses. But Sir Thomas Grainger Stewart possessed other literary gifts, and quite recently published a dramatic play in blank verse, "The Good Regent," and dealing with the days of Mary, Queen of Scots, which was received very favourably by the public.

In private life he was a most agreeable host and companion, a zealous Free Churchman, and in politics a strong Gladstonian.

The University of Edinburgh has thus to deplore the deaths of two medical professors within a year; last year of Professor Rutherford, now of the Professor of the Practice of Physic; the profession in Edinburgh has lost four outstanding members, only one of whom had passed the life limit of the Psalmist within the same period; Sir J. Struthers and Dr. John Duncan, in addition to the first two.

[The following further notes have been furnished to us by a former University class assistant of the late Sir Thomas.]



Sir Thomas Grainger Stewart was an Edinburgh man born and bred. He was educated at the University of Edinburgh, and although it is as a clinician that his name will be remembered, it may be of interest to some to know that he made his reputation first as a pathologist. For some time he was Pathologist to the Edinburgh Royal Infirmary and Lecturer on Pathology in the Edinburgh Royal College of Surgeons. That his abilities as an original investigator in that department of science were of a high order is evidenced by his classic work on diseases of the kidneys, a subject which, prior to his researches, was in this country at least a "*terra incognita*," and when the Chair of Pathology in the University of Edinburgh became vacant, Dr. Grainger Stewart was one of the strongest rivals of the late Professor Hughes-Bennett, who obtained the appointment.

But a man of his marvellous ability for imparting knowledge could not long be left in the background, and accordingly, in 1873, when the Chair of Medicine became vacant, Dr. Grainger Stewart was appointed. Since then, as a teacher of generations of Edinburgh students, his reputation has added lustre to the great school of which he was so brilliant a representative.

This is no place to catalogue the long list of his scientific and medical achievements. Suffice it to say that he was in no sense a one-sided man, even within the boundaries of his own profession. He was a pioneer not only in the study of renal affections, but also in modern neurology, his writings on peripheral neuritis being the earliest in this country to direct attention to that disease.

But although his writings are a model of concise statement and of elegant diction, it is not merely as a writer and original investigator that he will be longest remembered. As a lecturer and clinical teacher he has left his mark most deeply on the Edinburgh school. He was a polished and fluent orator of outstanding ability, and in his lucidity and power of explaining the most

complicated subjects he was unsurpassed. His lectures were more than the mere compression of a diligent reader, they were illuminated by a wealth of clinical experience and brightened by many an apt tale.

His genial and courtly manner, his tact, his *savoir faire*, were an object-lesson to all who were privileged to know him. To those qualities, moreover, was added a native shrewdness and a knowledge of men and things which made him a man of weight in any meeting, however cosmopolitan. The able way in which he filled the Presidential Chair at the Edinburgh meeting of the British Medical Association in 1898 was the subject of admiration to all who were at that gathering, and his mellow oratory was heard to similar advantage in Berlin at the last International Congress on Tuberculosis.

The following anecdote exemplifies his ready wit:—At a German congress a famous "renal" physician remarked to Sir T. Grainger Stewart: "Wir beide Nieren-artzensollten zusammen sitzen" (We two kidney specialists ought to sit together). Sir T. Grainger Stewart promptly replied:—"Also, lassen wir rückwärts bleiben" (Well then, let us keep close to the Back).

His literary gifts were not confined to the medical and scientific press. A couple of years ago he published a long romantic poem on the subject of the Regent Moray, which evinced a poetic vein of no mean order.

His presidency of the Edinburgh Royal College of Physicians, his appointment as physician to the Queen, his subsequent knighthood, and the various honours which were showered upon him by learned bodies at home and abroad, all those were but the well deserved rewards of a man whose memory will linger long, in the heart of many a friend and pupil in every quarter of the globe

BERNARD EDWARD BRODHURST, F.R.C.S.

THE death of Mr. B. E. Brodhurst removes from our midst one whose name had, for many years, been closely and honourably associated with progress in orthopaedic surgery. His claims to distinction in this department were fully recognised all over the world, and Mr. Brodhurst was correspondent and member of all the best-known orthopaedic societies.

Mr. Brodhurst took his member's diploma of the Royal College of Surgeons of England as long ago as 1844, becoming a Fellow in 1859. He was a copious writer on orthopaedic subjects, and in years gone by his contributions figured largely in the transactions of the principal metropolitan societies.

Among his works we may refer in particular to the well-known treatise on "Curvature in Diseases of the Spine," "Club Foot and Analogous Deformities," one on "Ankylosis," and "Lectures on Orthopaedic Surgery."

Mr. Brodhurst filled the post of surgeon to the Royal Orthopaedic Hospital and Royal Hospital for Incurables, also to the Belgrave Hospital for Children, and for many years he was attached to St. George's Hospital as surgeon and lecturer on orthopaedic surgery.

FRANCIS CHARLEWOOD TURNER, M.D., F.R.C.P.

WE regret to have to record the death at a comparatively young age of Dr. Francis Charlewood Turner, Physician to the London Hospital and to the North-Eastern Hospital for Children, &c.

Dr. Turner had, we are informed been in delicate health for some time past, but his death will come as a painful surprise to a large circle of appreciative friends.

Though not a very frequent speaker at medical societies of late years, Dr. Turner did a good deal of useful work, especially in relation to diseases affecting the circulatory apparatus the results whereof are embodied in contributions to various congresses and society transactions.

MR. WM. ADAMS, F.R.C.S.

WE regret to announce the death on Saturday last (the morning of his 80th birthday), from bronchitis and congestion of the lungs, of this well-known orthopaedic surgeon. He had retired from the active practice of his

profession some years, but up to within the last twelve months he was frequently called in consultation in severe and complicated cases. Mr. Adams was a voluminous writer on subjects connected with his specialty, and many of his works went into second editions. He was author of the Jacksonian Prize Essay of the Royal College of Surgeons, England, in 1864, entitled "Club-foot, its Causes, Pathology, and Treatment." The Lettsomian Lectures on "Rheumatic and Strumous Diseases of the Joints," and Lectures on "The Principles of Treatment Applicable to Contractions and Deformities," appeared first in the columns of this journal and were subsequently reprinted in book form. He occupied the presidential chair of the Medical Society of London some few years since, and at the time of his decease was consulting surgeon to the Great Northern Central Hospital, the National Hospital for the Paralytic, and the National Orthopaedic Hospital. Mr. Adams possessed a singularly amiable and kindly nature, which attached him to a wide circle of friends both in and out of the profession, all of whom will be saddened at the knowledge of his death.

SIR WILLIAM MILLER, M.B., J.P., LONDONDERRY.

A MUCH-RESPECTED citizen of Londonderry passed away on the 28th ult., in the person of Sir William Miller, M.B., J.P. He had been suffering from an attack of influenza, and had partly recovered, when some complications set in. He occupied a prominent place in the political and social life of Londonderry for more than forty years past. He was a magistrate of the city and also of the County Derry, a grand juror of the county, and a member of the City Corporation; he filled the office of chief magistrate on two occasions. Sir William was the second son of the late Joseph Ewing Miller, M.D., J.P., a gentleman who had held the office of Mayor of the City under the old Corporation before the Reform Act of 1840. Sir William gave a large portion of his time to the administration of the public affairs of the city and county, considering his professional engagements, and enjoyed a wide popularity. In the year 1875 he was first chosen mayor of the city during the vicereignty of the late Duke of Abercorn, and entertained that nobleman and the members of the Royal Agricultural Society during his first year of office. In the following year, having been re-elected mayor, he had conferred upon him the honour of knighthood, and was again chosen Chief Magistrate for the third year. Again he was elected mayor for the year 1888 and also for 1889. His professional appointments included that of surgeon to the county infirmary, medical officer of the prison, and surgeon-major of the militia. He had also an extensive private practice as a consulting doctor in the county as well as the city, where his advice was much sought after.

Medical News.

The Imperial Yeomanry Hospital Staff.

THE following is a list of the Medical Officers who have been appointed to the Imperial Yeomanry Hospital at the seat of war:—Lt.-Col. A. T. Sloggett, R.A.M.C., Military Commandant of the Imperial Yeomanry Hospital and Principal Medical Officer; Mr. Alfred Fripp, M.B., M.B.Lond., F.R.C.S.Eng., M.V.O., Chief Civilian Medical Officer; Dr. John Wichenford Washbourn, M.D.Lond., F.R.C.P.Lond., F.R.C.S.Eng.; Mr. Raymond Johnson, M.B., B.S.Lond., F.R.C.S.Eng.; Mr. F. Newland Pedley, F.R.C.S.Eng., L.D.S.; Mr. L. Vernon Cargill, F.R.C.S.Eng.; Mr. Hamilton A. Ballance, M.S., M.D.Lond., F.R.C.S.Eng.; Mr. William Turner, M.B., B.S.Lond., F.R.C.S.Eng.; Mr. John F. Hall Edwards, Surgeon-Radiographer and Photographer; Mr. Wallace C. G. Ashdowne, F.R.C.S.Eng.; Mr. J. S. Christopherson, M.D., B.C.Camb., F.R.C.S.Eng.; Dr. Andrew Elliot, M.D., C.M., Edin., D.P.H.; Dr. H. W. Saunders, F.R.C.S.Eng., M.B.Lond.; Mr. L. E. C. Handson, M.B., B.S.Lond.; Dr.

H. W. Bruce, M.D. Lond.; Mr. A. P. Parker, M.B., B.Ch. Oxon.; Mr. G. E. Richmond, M.B., B.S., B.Sc. Lond.; Mr. R. T. Fitzhugh, M.B. Lond., 1st F.R.C.S.; Mr. Barclay Black. The following will occupy the position of "Dressers" to the Surgical Staff:—Mr. J. Atkins, 1st M.B. Lond., 1st F.R.C.S.; Mr. A. Ayre Smith, 1st M.B. Durham, Surg. and Mid. Conj., C.A.S.W.; Mr. C. W. Brecks, M.B., C.M. Edin.; Mr. A. de V. Blathwayt; Mr. D. J. Greenfield, 1st M.B., 1st F.R.C.S.; Mr. M. B. Hay; Mr. A. Pearson, 1st M.B., 1st Arts Scholar; Mr. A. C. Ransford, 1st M.B.; Mr. Owen Richards, M.A. Oxon., 1st F.R.C.S., Fellow of New College; Mr. E. N. Thornton; Mr. J. G. Hamilton, Hon. Civilian Director of and Treasurer to the Imperial Yeomanry Hospital.

The Medical Sickness and Accident Society.

THE usual monthly meeting of the Executive Committee of the above Society was held on January 26th at 429, Strand, London, W.C. There were present Dr. de Havilland Hall, in the chair, Dr. J. B. Ball, Mr. J. Brindsey James, Dr. J. Pickett, Mr. F. S. Edwards, Dr. M. Greenwood, Dr. Alfred S. Gubb, Dr. W. K. Nowley Sibley, Dr. J. W. Hunt, Mr. William J. Stephens, Dr. F. J. Allen, and Mr. Edward Bartlett. The Committee examined special reports on all the cases of chronic sickness now on the books of the Society. There are now nearly twenty of such cases, and the evidence furnished to the Committee leaves little room for doubt that most of these members will continue to draw their sickness pay for the rest of their lives. The amount they receive varies from 150 guineas to 50 guineas per annum, and thus forms a very valuable provision. The influenza has once more greatly raised the number of sickness claims made upon the Medical Sickness and Accident Society, but during the year 1899 the total amount thus paid was less than that expected and provided for in the tables of contributions. Premiums and all particulars on application to Mr. F. Addiscott, secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

Grants in Aid of Scientific Research in Dentistry.

THE Odontological Society of Great Britain places at the disposal of persons engaged in original research on dental subjects, grants of money, on certain specified conditions; to wit, such grant is not to be applied in payment of personal expenses except when specially authorised, and the results of such researches are not to be published elsewhere than in the *Transactions* without permission. Apparatus purchased with the grant is to remain the property of the Society, and, lastly, a report (or an *interim* report) is required to be furnished to the committee within a stated period of the grant. Further particulars can be obtained from the Secretary, H. Lloyd Williams, Esq., 2, Upper Wimpole Street, W.

Vital Statistics.

THE deaths registered last week in thirty-six great towns of England and Wales corresponded to an annual rate of 27.5 per 1,000 of their aggregate population, which is estimated at 12,786,832 persons in the middle of this year. The deaths registered in each of the last four weeks in the several towns, alphabetically arranged, corresponded to the following annual rates per 1,000:—

Birkenhead 14, Birmingham 27, Blackburn 23, Bolton, 25, Bradford 24, Brighton 17, Bristol 19, Burnley 21, Cardiff 8, Croydon 10, Derby 24, Dublin 38, Edinburgh, 21, Glasgow 24, Gateshead 26, Halifax 22, Huddersfield 16, Hull 28, Leeds 23, Leicester 16, Liverpool 29, London 22, Manchester 23, Newcastle-on-Tyne 26, Norwich 26, Nottingham 19, Oldham 20, Plymouth 17, Portsmouth 17, Preston 30, Salford 25, Sheffield 22, Sunderland 30, Swansea 15, West Ham 18, Wolverhampton 29. The highest annual death-rates per 1,000 living, as measured by last week's mortality, were:—From measles, 1.4 in Bradford, 3.3 in Salford, and 3.9 in Preston; from scarlet-fever, 1.3 in Burnley and Preston; and from whooping cough 1.0 in Birmingham and in Liverpool, 1.3 in Preston and in Leeds, and 1.7 in Salford. In none of the large towns did the death-rate from "fever" or from diarrhoea reach 1.0 per 1,000.

The 98 deaths from diphtheria included 37 in London, 26 in Sheffield, 4 in Leeds, 4 in Liverpool, 3 in Glasgow, 3 in Brighton, and 3 in Leicester. One death from small-pox was registered in Hull, but not one in any of the other towns.

The Mortality of Foreign Cities.

THE following are the latest official returns, and represent the last weekly death-rate per 1,000 of several of the populations:—Calcutta 39, Bombay 101, Madras —, Paris 21, Brussels 16, Amsterdam 33, Rotterdam 28, The Hague 20, Copenhagen 21, Stockholm 18, Christiania 18, St. Petersburg 29, Moscow 30, Berlin 19, Hamburg, 17, Dresden —, Breslau 25, Munich 22, Vienna 20, Prague 24, Buda-Pesth —, Trieste 32, Rome 22, New York (including Brooklyn) 18, Philadelphia 21.

PASS LISTS.

Royal College of Physicians, Edinburgh; Royal College of Surgeons, Edinburgh; and Faculty of Physicians and Surgeons of Glasgow.

THE quarterly examinations for the Triple Qualification in Edinburgh were concluded on January 27th with the following results:—

First Examination, Four Years' Course.—Of nine candidates the following six passed the examination:—

Ed. Henry Smyth, David C. Williams, Honorine Forbes, James Levack, Ernest A. J. Ersser, Beadon Clarke, and one passed in the division of Chemistry.

First Examination, Five Years' Course.—Of fifteen candidates the following seven candidates passed the examination:—

Alexander B. H. Pearce, Adam W. Hall, William Fleming, William S. Batten, Lionel P. M. Alexis, Samuel J. Graham, Wilthew T. Nicholson, and two passed in Elementary Biology and one in Chemistry.

Second Examination, Four Years' Course.—Of fourteen candidates the following nine passed the examination:—

Alexander C. Campbell, William D. Lawton, H. E. Blackwood, D. C. Williams, Y. J. A. Campbell (with distinction), Thomas J. Evans, James M. Campbell, William E. MacManus, and Thomas Dow.

Second Examination, Five Years' Course.—Of twenty-three candidates the following fourteen passed the examination:—

John J. Adrien, Thomas W. McCubbin, Mary Lytle-Lytle, William J. Bates, John Boyd, Robert P. H. Blackstock, Donald Grant, Thomas Gibbons, Stanley L. G. D. MacLaine, Roger L. Williams, Samuel J. Mathewson, James MacLean, Henry Doig (with distinction), and John W. Cross, and five passed in Anatomy.

Third Examination, Five Years' Course.—Of thirty-two candidates the following twenty-one passed the examination:—

J. S. Colquhoun, J. Cotter (with distinction), D. McIntyre, A. J. Hewitt, J. D. J. Bruce, J. Flanagan, A. Buchanan, W. H. Ferguson, J. Crawford, W. Deery, E. G. Campbell, C. H. Farquharson, W. Turner, O. F. McCarthy, H. O. Pomme di Mirimonde, P. Carroll, A. H. Wilson, J. Newton, J. Stewart, C. H. Nash, and Sarah H. Smith, and two passed in Anatomy and three in Materia Medica.

Final Examination.—Of ninety-three candidates the following forty-six passed the examination, and were admitted L.R.C.P.E., L.R.C.S.E., and L.F.P. and S.G.:—

Winifred Nell, E. Burr, J. W. Dow, W. Astin, T. Duff, J. McElroy, G. F. Beachler, F. Jeeves, Isabella A. Watson, M. A. Alabone, A. J. Hewitt, W. Cunliffe, Hilma M. McFarlane, T. Logan, S. W. Morton, A. J. Morkill, B. Girdwood, A. E. Whitehead, T. Holmes, F. A. Georgeson, M. A. G. F. Stoney, F. P. Maitland, Matilda Coutinho, K. Eapen, C. K. Pillai, J. T. K. Thomson, C. A. Vogwell, J. B. Thorburn, G. H. F. Graves, W. B. Heagerty, M. Sullivan, J. Jeaffreson, J. A. MacLardy, W. H. A. Raffel, J. G. Gray, C. C. Beling, A. Bryans, T. Harrison, J. E. Boon, C. F. Brears, G. H. I. Hammerton, C. Bharadwaja, T. F. H. Blake, W. E. Cuthbertson, R. W. Perry, and H. O. Pomme di Mirimonde; and seven passed in the division of Medicine and Therapeutics, three in the division of Surgery and Surgical Anatomy, eleven in the division of Midwifery, and ten in the division of Medical Jurisprudence.

Notices to Correspondents, Short Letters, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a distinctive signature or initials, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

LOCAL REPORTS AND NEWS.—Correspondents desirous of drawing attention to these are requested kindly to mark the newspapers when sending them to the Editor.

READING CASES.—Cloth board cases, gilt lettered, containing twenty-six strings for holding the numbers of THE MEDICAL PRESS AND CIRCULAR, may now be had at either office of this journal, price 2s. 6d. These cases will be found very useful to keep each weekly number intact, clean, and flat after it has passed through the post.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

REPRINTS.—Authors of papers requiring reprints in pamphlet form after they have appeared in these columns can have them, at half the usual cost, on application to the printers before the type is broken up.

LADY APOTHECARIES.

LADIES can take out the license of the Irish Apothecaries' Hall on conforming with the regulations, which are almost identical with the other licensing bodies. Regulations to be obtained on application to Registrar. The Assistant's Degree is also open to ladies producing two years' service in compounding.

IRATA.—We fear you have no means of punishing a treacherous nurse except that of not employing her. Any communications on the subject made to fellow-practitioners had better be verbal, as otherwise you would run the risk of an action for libel.

N. T. S.—You will find what you require in the "Aids to Gynaecology" (Baillière, Tindall, and Cox), but we would strongly advise you to consult the larger text-books in preparing for examination.

G. S. A. (London).—It only takes about a quarter of an hour to stain for the gonococcus, but no power under a twelfth is likely to prove satisfactory. You must bear in mind, too, that while the presence of the organism is conclusive evidence of the specific nature of the affection, its absence does not prove the contrary. Bacteriological investigation and clinical observation must go hand in hand in deciding these difficult cases.

HYSTERICAL INSANITY.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—In the report of the conclusion of my address to the Gynaecological Society that appeared in your issue of January 31st, in quoting from Dr. Clouston on "Hysterical Insanity," the percentage should read 2 per cent., not 50 per cent.

I am, Sir, yours truly,

H. MACNAUGHTON-JONES.

Dr. A. I.—A very good formula for a vesicant plaster, the use whereof is not attended by pain, is: Menthol chloral acid, 1 part; spermaceti, 4 parts; cacao butter, 2 parts. Mix and spread on a piece of linen.

MR. JOHN EWENS, of Bristol, calls our attention to a printer's error in his paper on "A comparatively Rare Injury to the Distal Phalanx of the Finger," on page 85 (Jan. 24). The word "alternated" in the second line of the last paragraph should read "attenuated."

"NOW AND THEN."

A CORRESPONDENT writes concerning a parallel drawn under the above title in this journal between our service at the Crime and in the present campaign. He points out that there were just as many volunteer surgeons drawn from civilian sources. He further quotes from a *runch* of the Crimean period a verse that has a somewhat striking general resemblance to recent lyrics:—

"Listen, soldier, to the tale of the tender Nightingale
Tis a charm that soon will ease your wounds so cruel,
Singing medicine for your pain in a sympathising strain,
With a jug, jug, jug of lemonade or gruel."

MR. E. DEAN MARRIOTT (Nottingham).—Letter arrived as we were at press. Is unavoidably held over.

Meetings of the Societies and Lectures.

WEDNESDAY, FEBRUARY 7TH.

OBSTETRICAL SOCIETY OF LONDON.—8 p.m. Specimens will be shown by Dr. A. Routh, Dr. Griffith, and others. Annual meeting. The President (Mr. A. Doran): Annual address.

SOCIETY OF ARTS.—8 p.m. Mr. E. Wilson: Housing of the Poor. **ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN** (Leicester Square).—4.30 p.m. Dr. Eddowes: Burns, Scalds, and Scars. (Post-graduate Course.)

THURSDAY, FEBRUARY 8TH.

NEUROLOGICAL SOCIETY OF LONDON (11, Chandos Street, W.).—8.30 p.m. Annual General Meeting for Election of Officers. Dr. A. Waller: On the Excitability of Nervous Matter, with special reference to the Retina (Presidential Address).

FRIDAY, FEBRUARY 9TH.

CLINICAL SOCIETY OF LONDON (20, Harrow Square, W.).—8.30 p.m. Papers: Dr. Rolleston: A Case of Fatal Hæmo-pneumothorax of unexplained origin. Mr. R. Jones and Mr. Tubby: Further Experience of Cases of Spinal Rectification. Dr. J. J. Perkins and Mr. C. S. Wallace: A Case of Perforated Duodenal Ulcer, Operation, Recovery.

ROYAL INSTITUTION OF GREAT BRITAIN.—9 p.m. Prof. J. R. Green: Symbiosis and Symbiotic Fermentation.

Appointments.

AUBREY, THOMAS, M.R.C.S. L.R.C.P., Assistant House Surgeon to the Bristol General Hospital.
FLOYD, E. W., M.B., Ch.B. Vict., Resident Medical Officer to the Guest Hospital, Dudley.
HAWTHORNE, C. O., M.D. Glasg., M.R.C.P. Lond., Examiner in Materia Medica and Therapeutics in the University of Edinburgh.
JONES, P. T., L.R.C.P. Lond., M.R.C.S., Medical Officer for the Coleford Sanitary District of the Frome Union.
MORLEY, G. F., L.R.C.P. Lond., M.B.C.S., Medical Officer for the Portsmouth Sanitary District of the Portsmouth Island Union.
MULLEN, W. L., M.D., Ch.B. Melb., Acting Medical Superintendent of the Metropolitan Lunatic Asylum, Victoria, Australia.
PALMER, C. S., L.R.C.P., M.R.C.S., Medical Officer for the First Sanitary District and the Workhouse of the Reigate Union.
RIDSDALE, A. E., L.R.C.P. Lond., M.R.C.S., Medical Officer for the First Sanitary District of the Newhaven Union.
ROBSON, F. W. H., M.B., C.M. Edin., Medical Officer for the Burrough Sanitary District of the Ormskirk Union.
STEDMAN, S. B., L.S.A., Medical Officer for the Swinhope Sanitary District of the Caistor Union.
WELD, J. C., L.K.Q.C.P. Irel., Officer of Health for the borough of Carisbrook, Victoria, Australia.
WIGGINS, H., L.R.C.P. Lond., M.R.C.S., Medical Officer for the Second (B) Worthing Sanitary District of the East Preston Union.

Vacancies.

Bath General or Royal Mineral Water Hospital, Bath.—Resident Medical Officer, unmarried. Salary £100 per annum, with board and apartments.
Borough of Southport.—Medical Officer of Health for the Borough. Salary £500 per annum. Apply to the Town Clerk, Town Hall, Southport.
Brixton Dispensary, Brixton, S.W.—Resident Medical Officer for two years unmarried. Salary £150, with furnished apartments, attendance coals, and gas.
City of Liverpool.—Assistant to the Medical Officer of Health. Salary £350 per annum, subject to certain conditions. Applications to the Town Clerk, Town Clerk's Office, Liverpool.
General Infirmary at Gloucester and the Gloucestershire Eye Institution.—House Surgeon. Salary £100 per annum, with board, residence, and washing.
Hants County Asylum, Fareham.—Third Assistant Medical Officer, unmarried. Salary commencing at £125 per annum, with furnished apartments, board, washing, and attendance.
Royal Infirmary, Sheffield.—House Surgeon for three years. Salary £120 per annum, with board, lodging, and washing.
Royal Sea Bathing Hospital, Margate.—Resident Surgeon. Salary £100, with board and residence. Apply to the Secretary, Royal Sea Bathing Hospital Offices, 30, Charing Cross, London.
Ventnor Royal Hospital for Consumption and Diseases of the Chest.—Assistant Resident Medical Officer. Salary £100, per annum, with board and residence. (See advt.)

Births.

WILLIAMS-FREEMAN.—On January 30th at Wavhill, Andover, the wife of John P. Williams-Freeman, M.D., of a daughter.
WINGFIELD. On February 3rd, at Winchester, the wife of Hugh E. Wingfield M.D., of a daughter.

Marriages.

GABE-ISON.—On February 1st at St. Helen's Church, Ashby-de-la-Zouch, John Kees Gabe, M.D., M.R.C.S., of 16, Mecklenberg Square, London, to Grace Winifred, daughter of Edward Ison, Esq., of Ashby-de-la-Zouch.
MCGEAGH RYDER.—On January 31st, at St. Mary's, Crumpsall, Manchester, William McGeagh, M.D., of Liverpool, to Eliza Jane, only daughter of the late W. B. Rydger, J.P., of Gransden Hall, Hunts.
MUDIE SOMERSET.—On January 27th, at All Saints, Margaret Street, London, W., Arthur Mudie L.R.C.P. Edin., of York Lodge, West Norwood, to Marianne, daughter of the late Francis Somerset.

Deaths.

ADAMS. On February 3rd, at his residence, 7, Loudoun Road, St. John's Wood, N.W., Wm. Adams, F.R.C.S. Eng., on his 86th birthday.
BRODHURST. On January 30th, at his residence, 21, Portland Place, London, Bernard E. Brodhurst, F.R.C.S. Eng., late surgeon and lecturer on Orthopaedic Surgery at St. George's Hospital, London, aged 75 years.
SEWELL.—On January 28th, at Lintoch House, Canterbury, Charles Brodie Sewell, M.D. Lond., aged 183 years.
SUTCLIFF.—On January 29th, at Torrington, N. Devon, Edward Sutcliffe, M.D., aged 161 years.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXX.

WEDNESDAY, FEBRUARY 14, 1900.

No. 7.

Original Communications.

THE RISKS OF UNOPERATED UTERINE FIBROMYOMATA.

By E. STANMORE BISHOP, F.R.C.S.Eng.,
Hon. Surgeon Ancoats Hospital, Manchester.

THAT all concerned, patient and surgeon alike, should have shrunk from the risks involved in removal of a myomatous uterus in the days when such a procedure had a mortality of 70 to 80 per cent., as it had in 1878, was but natural; especially when experience also showed that in many cases, if the sufferer could struggle on until the menopause, she could escape with her life, indeed, though maimed and impoverished. That the menopause was always delayed in these cases, sometimes to a great extent, was only part of the burden she had to bear, and it is characteristic of women that they do bear such daily, monotonous, wearying burdens with marvellous patience and angelic fortitude. Their duty to their husbands, and above all, to their children, appeared absolutely to forbid their resort to what was then such a desperate way of escape. Through weeks, months and years of discomfort, pain, and the numberless, undefinable, but none the less real miseries due to want of sufficient blood to carry on the various functions of life, they bravely struggled, upheld always by the bright hope insisted upon, and properly so, under those circumstances, by their medical attendant, of a happy issue when once the "change of life" was over. The thought that they would have passed by that time the "summer of life" and all its pleasures, was thrust out of sight, and their troubles accepted by some in a religious spirit as the "cross" they had to bear, by others as part of the common lot of life, in all cases as inevitable; a thing that could only be relieved, a thing, however, which was essentially temporary, and from which time would bring entire release.

Under such circumstances, too, it was certain that medical men in their relations with such patients would lay stress upon the probabilities of such a result, and would depreciate the dangers of the actual position; that text-books and lecturers would reflect the prevailing view of the situation; that unpleasant incidents would be treated as very exceptional, and as in no way altering the main aspect of things. Even if here and there someone realised the risks which any patient suffering from fibromyoma ran, the proportion of these to the 70 per cent. of operation appeared far too little to justify the latter.

But these views require revision when the mortality sinks from 70 to 80 per cent. to 2 to 7 per cent. as it is to-day. Most surgical opinions are bound to depend very greatly upon comparisons, and in direct proportion to the increased safety of operative interference, the dangers and discomfort of any condition

remediable by surgery rise in importance. The discomforts of fibromyoma are known to every medical practitioner; it is wise also to consider more closely than heretofore the actual dangers of unoperated cases.

Such dangers may be divided into two classes. First, those directly due to the presence of the growth itself; secondly, those which render late operation so dangerous when at last it is undertaken—dangers, I mean, not directly due to the operation itself, but imported into it unnecessarily by changes in the tumour itself or in the parts around by delay in resorting to this, the only sure remedy. The latter have their part also in the first category—they themselves sometimes produce a fatal result before any operation is done, but the point I wish to enforce is they do more than anything else to increase the immediate risks in any such operation, and that all of them are avoidable, and utterly unnecessary, if surgical aid is obtained sufficiently early.

The inherent dangers are five: Death from hæmorrhage, death from sepsis, death from pressure upon important organs as intestine, producing intestinal strangulation, or ureter, producing hydronephrosis, pyonephrosis or anuria. Death during pregnancy or following parturition, or abortion. Death from cardiac degeneration owing to persistent loss of blood.

In 1887 More Madden (a) wrote "I cannot call to mind ever seeing any case in which death resulted directly from this disease," and Wallace, of Liverpool said "I have never known a case succumb to hæmorrhage. It can always be checked." These statements represent the ideas currently held at that time. That they were incorrect, and based upon a defective or too restricted knowledge is evident if search is made either among museum specimens, or records of cases. In the College of Surgeons, (England) Museum, No. 4723, is a specimen removed from a young woman after death from profuse hæmorrhage. The specimen is sent by Dr. Goodhart.

In St. Bartholomew's Hospital Museum is a preparation, No. 2985, Ser. 43, from a case in which death resulted from hæmorrhage following spontaneous opening of an uterine sinus in a case of fibromyoma. The case is described in the *Edinburgh Medical Journal*, 1863. Vol. 9 p. 627, by Dr. Matthews Duncan.

Dr. Favell (b) in 1889 reported a case in which the patient died from sudden and profuse hæmorrhage.

Bignon (c) in 1892, reported a case in which death was caused by internal hæmorrhage following the rupture of a sinus at the back of a large tumour, after a blow upon the abdomen.

Deaths due to sepsis are more frequent, and are usually secondary to necrosis of the tumour itself.

In St. Bartholomew's Hospital Museum No. 2951 A is a specimen in which death was due to the after

(a) *British Medical Journal*, 1887. Vol. 1, p. 52.

(b) *British Medical Journal*, 1889. Vol. 2, p. 1,159.

(c) *Nouv. Arch. d'Obstet. et de Gynec.*, 1892. Supplement, p. 159.

effects of a sloughing fibroid. In this case the matting of intestines above in order to shut out the infective material from the general peritoneal cavity is well shown; whilst the tendency to pocketing of pus in cavities below is equally illustrated.

Gervis (a) in 1883 reported a case in which a large submucous fibroid sloughed suddenly and completely, without any obvious cause or premonitory symptoms. There was also double pyosalpinx and one tube had ruptured, causing fatal peritonitis.

Lediard (b) in 1883 reported a case of death from sepsis, miliary abscesses being found in both kidneys, and infarcts in the spleen, and again in 1894, (c) another of death from peritonitis, with miliary abscesses in the kidneys and septic changes in other organs.

Edis (d) in 1888 reported a fatal case with acute general peritonitis; both Fallopian tubes thickened and distended, whilst both ovaries contained small abscesses.

Cotter (e) in 1889 reported a case with diffuse suppurative peritonitis, and death in consequence.

Schatelig (f) reported a case where death was due to chronic general peritonitis.

The St. Thomas Hospital Reports of 1895, give particulars of a case admitted with a large sloughing fibroid. Patient died without operation from septicæmia.

Dr. Lombe Atthill (g) in 1881 reported a case in which pus was found in the tissues of an uterus, containing two large fibroids, removed after death, and in which case a fatal result followed from septic embolic pneumonia.

Deaths from pressure on important organs, as the ureter are mentioned by Kelly (h), Henry Morris (i), and Gouget (k). In the Transactions of the Obstetrical Society of London a case is reported by Cullingworth (l) in which pressure upon the intestine had been so great that the cæcal wall gave way from over-distension, and fæces escaped into the abdominal cavity, producing a fatal result. In the College of Surgeons' Museum (London) is a preparation, No. 4642, from a case in which death was caused by strangulation of a coil of intestine by a band formed between two calcified fibromyomatous masses.

Although fibroid disease appears to favour sterility in women, it by no means ensures it, and should pregnancy occur the risk to life is greatly increased. Abortion under these circumstances is very likely to occur, and should it do so, the prognosis becomes very grave. Should the tumour be interstitial, the due contraction of the uterus afterwards is greatly obstructed, whilst if submucous, and the attachment of the placenta have any relation to it, hæmorrhage from this site becomes almost uncontrollable. Lefour collected thirty-nine cases of abortion with fourteen deaths, a mortality of 36 per cent.

The College of Surgeons' Museum contains a specimen, No. 4639, taken from a woman who died twelve hours after an abortion at four months. Peritonitis with high temperature preceded the abortion. The tumour in this case was not even interstitial, but subperitoneal, and attached by a pedicle four inches long, to the left side of the fundus uteri.

Parturition in cases of fibroid tumour is always a matter of difficulty, often of grave danger. Of 147 cases collected by Susserott (m) the forceps were

required in 20, with a loss of 8 mothers and 13 children. In 21 cases, the placenta required manual removal, and of these 13 women died. Collectively, the maternal mortality was 53 per cent., the infantile 66 per cent. Tarnier, out of 6 cases delivered by forceps, lost 4 mothers and 4 children. Five women with fibroids died before delivery. Hogan reports a case of pregnancy in a fibroid uterus. Death. Some cases are not capable of delivery by the natural route. Sanger collected 43 cases where Cæsarian section became necessary—the maternal mortality was 83·7 per cent. Pozzi, 28 cases, maternal mortality 86 per cent. Johnston estimates that during pregnancy or labour one-third of the mothers and more than half of the children die; and recommends celibacy where the tumour cannot be removed.

Excessive and persistent losses of blood have their own effect upon the central organ of the circulation. At the Berlin Congress of Gynæcologists in 1899, Gottschalk insisted on the degeneration of the myocardium frequently associated with fibromyomata. Freund said that diseases of the heart and blood vessels are very commonly associated with them, and that they are on that account far less innocent than is generally supposed. Kelly says that "hyaline degeneration of the heart, muscle, and arterial sclerosis are sometimes seen in old cases," Hoffmeier speaks of the frequency of cardiac disease in cases of abdominal tumour, especially in fibromyomata. He collected 18 cases in which sudden death occurred from heart failure, 3 of fatty disease, and 15 of brown atrophy.

But especial importance attaches, I conceive, to changes in the tumour or its environment due to delay, and which immensely increase the danger of operative interference when, at last, it becomes imperative.

In the first place, however, without any of the changes to be described, excessive previous losses of blood may so deplete the patient as to render her unable to bear the necessary traumatism involved in even a slight operation. This is illustrated by a specimen, No. 4632 in the Hunterian Museum, taken from a patient of Sir Spencer Wells. The woman was æt. 32. She had had profuse menorrhagia for several years, threatening her life. The patient died of shock four hours after a comparatively easy enucleation.

The changes referred to are of five kinds.

First and foremost is the danger of inflammatory adhesions. These are often complicated with if not entirely due to inflammations occurring in the Fallopian tubes and ovaries. Meredith in an analysis of Tait's cases, estimated that 54 per cent. were complicated with tubal disease, and 46 per cent. with chronic ovaritis. Twombly estimated that 50 per cent. of interstitial fibroids were complicated with affected tubes sooner or later in their course. These complicate unnecessarily operations in three ways. First, they greatly lengthen the time required for the safe enucleation of the tumour or uterus. Secondly, by their contraction, they alter the normal relation of parts, rendering possible, even probable, the laceration or wounding of the gut or ureter, and anyone who has had, as a sequel to a tedious hysterectomy, to suture either the one or the other, knows how immensely the chances of such a patient have been decreased, both by the time during which the abdomen must remain open, and by the additional traumatism, to say nothing of the prospect in after years, should the patient survive, of possible stricture of one or the other tube. Thirdly, there is the risk of leakage of some infective material during the process of removal. A very good idea of the formidable problem presented to the surgeon in such cases, may be obtained by a study of a preparation in St

- (a) "Trans." Obstet. Soc., July 4th, 1883.
- (b) *Brit. Med. Journ.*, 1883. Vol. II., p. 941.
- (c) *Brit. Med. Journ.*, 1884. Vol. II., p. 372.
- (d) *Brit. Med. Journ.*, 1888. Vol. 2, p. 940.
- (e) *Brit. Med. Journ.*, 1889. Vol. 1, p. 194.
- (f) "Arch. f. Gynak. u. Geburttech." Bd. 1, p. 425.
- (g) *Brit. Med. Journ.*, 1881. Vol. 2, p. 1058.
- (h) "Operative Gynæcology." Vol. 2, p. 539.
- (i) *Brit. Med. Journ.*, 1881. Vol. 1, p. 793.
- (j) "Full. de la Soc. Anat." Par. 1892. P. 232.
- (l) "Trans." Obst Soc. Lond. 1897. Vol. 39.
- (m) *British Gynæcological Journal*. August, 1898. See Jes sett.

Bartholomew's Hospital Museum, numbered 2951A, contributed by Dr. Griffith.

Secondly, and often associated with the above, is the chance of necrosis or sloughing of the fibroid itself. In the Transactions of the Obstetrical Society, Vol. 32, p. 171, is an account by Mr. Bland Sutton of a case in which death resulted from peritonitis a few days after an operation for removal of a sloughing myoma. At the autopsy, shreds of gangrenous tissue were found projecting from the abdominal ostia of the Fallopian tubes. The specimen, No. 4602A, is to be found in the College of Surgeons' Museum.

Thirdly, there is the possibility of pressure upon the ureters, with the resulting changes in the kidneys thus produced. I have already referred to these.

Fourthly, in many of these cases, and apparently directly due to the persistent losses of blood, cardiac disease occurs. Authorities have already been quoted for this statement. It is needless to point out how seriously such cardiac changes affect the chances of the patient during and after operation.

Fifthly, a broad ligament fibroid may grow in such a direction as to undermine, and spread out the meso-cæcum or meso-sigmoid. During its development, the changes in position of the overlying gut are so gradual, that no symptoms may be apparent. Removal of the tumour, however, produces at once a sudden alteration, and occlusion or gangrene of the intestine may result. Cases in which this has occurred with fatal results are recorded by various authors.

I have refrained from multiplying instances of these various dangers, but enough are given to prove their reality.

A ghastly account of an operation too long delayed is given by Platonoff. In this case, after opening the abdomen the adhesions were found to be so dense, that all hope of removing the tumour was abandoned. It was, however, now found impossible once more to close the abdominal opening. On two separate occasions, an attempt was made to remove portions of the growth with the cautery, but this had to be given up on account of profuse hæmorrhage. Gangrene set up in the exposed portion of the myoma, which spread upwards. Death ensued. Can anything more horrible be conceived?

But short of anything like this, the operations described by the elder Keith, or by Schröder demonstrate the excessive difficulties encountered by them, and which could only be surmounted by extreme patience, skill, and dexterity. Such cases are still found, and successful results are with them but a small percentage even yet.

It is constantly affirmed that these tumours grow so slowly that many years must elapse before danger arises. This might be true if the danger were confined solely to pressure effects from actual size. Not entirely, however, since fibrocystic degeneration may very rapidly alter the mere size of the growth; but, as I have tried to show, this is by no means the only, or, indeed, the chief risk. A few days since I removed an uterus containing three fibroids the size of apples, besides numerous smaller nodules. In two of these necrotic changes had gone so far as to produce small cavities, the size of large walnuts, containing pus, whilst the left ovary was a bag of pus, firmly adherent to the broad ligament. The symptoms in this case had only existed, so far as the patient knew, for twelve months.

Hermann and Treves have described a case in which such a necrotic focus formed in a fibroid, and discharged itself into the uterine canal, so that on dilating the os, the finger passed into the cavity. Symptoms of disease had existed here for only eight years. The specimen is preserved in the College of Surgeons' Museum, No. 4609B.

Inflammatory adhesions, pyosalpinx, ovarian abscess, sloughing of the tumour itself, &c., are of far more importance than any mere increase in size, and when they occur, not only do they greatly add to the ill-health of the patient, but they immensely increase the difficulties of the surgeon.

Should a cancerous nodule be detected in the uterus of any woman, all surgeons advise immediate operation—but how often is this followed by disappointment? The growth returns, in the scar, in the broad ligaments, in distant organs. The surgeon's handiwork is useless in most of such cases, and the patient sinks into deeper despair at the non-fulfilment of her hopes. She has pluckily gone through what must always be a terrible ordeal for her to face, and her courage, her patience, are all thrown away. In fibromyomatous disease—I am not speaking of sarcoma, sometimes included as a degeneration of this form of tumour—once the diseased organ is removed, and the immediate dangers of the operation are surmounted, there is no return to fear; the thing is over and done with, the unfortunate sufferer is once more completely restored to health and strength, whilst the surgeon has the intense satisfaction of contemplating good work effectively done. Surely it is worth while to ensure a good result by operating under the best possible conditions, and such conditions are only to be obtained in the earlier stages, before inflammatory changes have complicated the case.

If the considerations above detailed are allowed to have their full weight, we ought to hear less of waiting for the menopause in these cases, and, although the statistics of operative work have already immensely improved, the rate of mortality should become still less with earlier, and therefore less dangerous, interference.

THE DILATATIONS AND DIVERTICULA OF THE ŒSOPHAGUS.

By JOHN KNOTT, M.A., M.D., CH B., and Dip.
Stat. Med. (Univ. Dub.); M.R.C.P.I.; M.R.I.A.; &c.

(Continued from page 136.)

In proceeding to discuss the *acquired* forms of dilatation of the œsophagus, the classification of Rokitansky will be found correspondingly convenient. I may, however, mention that in his very excellent work on "Diseases of the Throat and Nose," the late Sir Morell Mackenzie treats the subjects of "Dilatations of the Gullet" under the divisional headings of "Simple Dilatations" and "Traction Diverticula" (of Zenker and Ziemssen). Of these the "simple dilatations" may be either primary or secondary, the former occurring without any obvious cause, and the latter being the result of the stricture of the œsophageal canal at the lower level." He also informs us that the *primary* dilatations "are cylindrical or fusiform in shape, generally affecting the whole length and circumference of the œsophagus, and usually attaining their maximum girth in the thoracic region about the middle of the gullet." The same authority attributes the occurrence of greatest expansion in this situation to the looseness of its connections, on account of which there is so little external pressure.

The number of recorded cases of the *cylindrical* or *fusiform* variety of dilatation is comparatively very small. It is noteworthy that the symptoms in most of the instances—even when not supposed by the observers to be of congenital origin—had commenced before reaching adult age. Indeed, I entirely agree

with the suggestion made by Mackenzie that "it is probable that in many of these cases the predisposing local weakness had existed before birth." Albers long ago expressed the belief that it always originated in this way.

Without quite committing myself to so absolute an opinion as that of the latter pathologist, I will proceed to observe that in the recorded cases of cylindrical or fusiform dilatation of the œsophagus, the amount of expansion was, nearly always, very great. Also, that in the majority of instances, the condition was accompanied by hypertrophy of the walls of the tube, especially of the muscular layers; while in a few instances the opposite condition of attenuation and atrophy existed. This striking contrast makes me to suspect a difference or origin in the respective groups of cases, and I believe that a sufficient number of instances are now on record to show pretty conclusively that the condition in some of them originated in after life.

A case bearing specially upon this question and of great interest, both in its clinical history and pathological anatomy, was published by Hannay in the *Edinburgh Medical and Surgical Journal* of July, 1833:—

"J. L., æt. 38, had suffered from dysphagia from early boyhood. The commencement dated from the receipt of a violent blow on the chest. Ever since he had suffered from uneasiness in the epigastric region, and difficulty in swallowing, the morsel appearing to be arrested opposite a little point above the lower end of the sternum, and giving rise to the most painful and protracted efforts of deglutition. The symptoms became gradually worse, and had lately amounted to an agonising sense of distension, which remained for several hours after each meal. Immediate relief could be obtained by vomiting. The passage of a probang met with no obstruction. He had of late complained of a constant sense of oppression in the chest, made worse by any violent exertion. His symptoms were always aggravated by any intemperance. . . . He was found dead one night in his chair, after walking home about two hours before from a supper party, where he had indulged rather freely in the good things of the table."

On examination the œsophagus was found enormously dilated, and filled with ingesta.

"The dilatation began immediately on its entrance into the chest. The cervical portion was perfectly natural. It grew gradually wider till it reached the middle of its course in the thorax, there the sac measured, as it lay collapsed on the table and unopened, rather more than three inches across, and when fully distended with fluid, more than six inches in circumference. The thoracic portion alone required about eight gills of water to fill it, and when so filled it looked like the arm of a person fifteen or sixteen years of age. From the middle of the thoracic portion it gradually diminished in capacity till it reached its appropriate aperture in the diaphragm, where it was of its natural dimensions. . . . The parietes of the tube were several times their ordinary thickness, and, comparatively speaking, dense and strong; they had lost almost all trace of muscular texture; the appearance of a section of these reminded me of a piece of sole or thick leather. They had a good deal of blood in them and seemed very vascular. Its internal or mucous coat seemed very vascular, arborescent, and red; it was, as it were, spotted with abrasions of its cuticle, and felt rough and scabrous to the finger. Some parts are smooth, and being less red, appeared almost natural. There was no obstruction, either by tumour external to, or constriction within, the canal."

In his remarks on this case, Hannay expresses his belief that the appearances above described were the result of repeated attacks of inflammation. The

vascularity and swollen condition of the walls of the tube supported this view; so also did the symptoms which had been present during life: the painful sensations, the aggravation by any act of intemperance, &c. "The surface, absorbed and irritable-looking, had all the appearance of recent inflammation." The explanation of the process of enlargement, which he gives in concluding, appears to me to be quite satisfactory. "Repeated attacks of inflammation of the œsophagus had probably destroyed its muscular structure and its contractile power. Swallowing was impaired; the food was detained and accumulated; and the distension of the ingesta had by degrees mechanically dilated the canal." The first attack had probably followed the injury which the organ had sustained at the time of the receipt of the blow.

Rokitansky appears to me to have had the above case in his mind's eye when he says, in speaking of dilatation: "It appears to be sometimes the consequence of a concussion of the œsophagus by a blow or contusion of the chest." These words are, to say the least, very indefinite; and he does not trace the development of the pathological condition any further. Niemeyer questions this explanation; but like Rokitansky himself, does not seem to have considered the sequence of the changes to which the results of the application of such violence may give rise. Another theory of the origin of dilatation, which Niemeyer mentions only to condemn, is that of Oppolzer, who had attributed its origin in some cases to the treatment of gout by imbibition of large draughts of warm water. I entirely agree with Niemeyer in the negative opinion that the draughts of warm water were not the effective agents in the production of this condition. The patients who had been in the habit of using them were of a well-established gouty diathesis. It has been satisfactorily demonstrated that some gouty patients have been subject to repeated attacks of inflammation of the gullet. There can hardly be a question raised in objection to the statement that one of the inevitable consequences of such repeated attacks of inflammation would be a diminution of contractility and elasticity in the walls of the tube; as a consequence of which they must easily yield to pressure of any kind, whether applied by the media of "large quantities of warm water" or of the ordinary ingesta. Accordingly, it is to the gouty condition—with its complications and sequelæ, that I attribute the œsophageal dilatation in such cases; an opinion in which, I am glad to say, I have been supported by the testimony of my late distinguished friend Sir Morell Mackenzie in his criticism of this view—which I had announced in the verdant days of my medical studentship.

A very interesting and remarkable case of dilatation of the œsophagus, attributed to the strain produced by lifting a heavy weight, has been placed on record by my friend Dr. Henry Davy, of Terenure, Dublin:—

"The patient, a gentleman of 38, had given himself a severe strain in lifting a heavy weight, and felt as if something had given way inside. From that period he had suffered from difficulty in swallowing, and nausea and vomiting after taking food. If he attempted to lie on his left side he felt a smothering sensation, and soon threw up quantities of a slimy fluid, which was free from acidity or disagreeable taste. The symptoms gradually became more aggravated. When seen for the first time by Dr. Davy, he suffered from a feeling of 'raking or tearing' in the epigastric region whenever he attempted to swallow. He also suffered from a sensation of heat and burning along the course of the œsophagus, and experienced an obstruction to the passage of food opposite the right margin of the ensiform cartilage.

He vomited considerable quantities of slimy mucus, especially in the morning after sleep. 'The sickness was in a great measure relieved by lying on the right side; his appetite was craving and he suffered much from thirst.' In the epigastrium there was felt a pulsation resembling that of aneurysm. In this situation there was also considerable pain, and tenderness on pressure; and on percussion there was marked dulness. He was also suffering from obstinate constipation, and had a hard, dry cough.

"Under treatment he recovered so well as to be able to resume his situation, and during the next five years the only inconvenience from which he suffered was that he was obliged to take his meals in a semi-recumbent position, with his right arm over the back of a chair, having found by experience that this was the only posture that would allow the passage of food into his stomach; in any other position he felt very uncomfortable, and experienced a smothering sensation that brought on a fit of coughing.

"A sudden aggravation of his symptoms, like that for which he had been treated by Dr. Davy, proved fatal, in about eleven days, from inanition, the stomach retaining no food.

"On post mortem examination, the œsophagus was found 'enormously dilated throughout its entire course, resembling the colon in appearance when distended with air, and measuring at its broadest part (the upper part of its lower third) nine inches, and through the rest of its circumference above and below about eight inches; its muscular coat was very much hypertrophied. The œsophagus was slightly distended with flatus, and contained about a wineglassful of brown fluid like tea, which was prevented from entering the stomach by a twist or volvulus at its cardiac extremity, at its passage through the diaphragm. The circumstance, in my opinion, accounted for the facility which which Mr. R— swallowed when he stretched himself, by undoing, so to speak, this twist. On filling the œsophagus with water, we found it was capable of holding two pints of fluid, and we observed that the mucous membrane was studded at the dilated part with several irregularly-shaped ulcers, varying in size from a pin's head to a two-shilling piece. We also perceived innumerable small white spots (cicatrices), the remains, no doubt, of old ulcers which had healed. The cardiac extremity of the œsophagus readily admitted the index and middle finger, and there was no indication of malignant disease, aneurism, or tumour.'"

It is worthy of note that in neither Hannay's case nor Davy's did the general nutrition of the patient's system seem to suffer so much as might have been anticipated from the severity of the symptoms.

In a case recorded by Purton ("London Medical and Physical Journal," XLVI, 540), the patient sank exhausted from the effects of dysphagia, which had commenced in boyhood. It was first noticed after the receipt of a violent blow on the sternum, and had continued—with progressively increasing severity. There were, however, irregular periods of greater or less remission of the symptoms, and this state of things went on to the period of his death. On examination, the œsophagus was found dilated; the expanded portion forming a sac which reached from two inches below the pharynx to the cardiac orifice. The interior of this sac presented, in a certain (slight) degree, the rugous appearance of the gastric mucous membrane.

Another case, which appears to be somewhat better known than those already given, was published by Mayo. The patient, a female, died at the age of 33, in a state of extreme emaciation. This condition was the result of persistent vomiting of all food; almost everything was rejected a few minutes after swallowing, except when a large draught of fluid was

taken, a certain portion of which was usually retained. Nothing else seemed to her to quite reach the stomach. At the autopsy the œsophagus was found to be enormously dilated—excepting about an inch and a half of its pharyngeal, and an inch of its cardiac, extremity. The greatest expansion was at a distance of four inches from the cardiac orifice, where the tube, when distended, presented a diameter of two-and-a-half inches. The symptoms had commenced during pregnancy, and had lasted ten years before the fatal result.

(To be continued.)

Therapeutic Notes.

By GEORGE FOY, M.D., F.R.C.S.I.

THE EFFECTS OF ANTIPYRIN IN EXCESSIVE COFFEE DRINKERS.

IN a recent communication to the Société Médicale du Louvre, two cases were brought forward of nervous attacks, accompanied by eruptions, following on the use of antipyrin in patients who were addicted to the abuse of coffee (Dr. Pappillon).

The author considers the effects of the excessive use of coffee and of alcohol produce very similar, if not identical, the delirium tremens of coffee drinking being in every respect the same as the delirium tremens of alcohol.

His first case (*La France Médicale*), was that of a young Belgian girl, æt. 19, born of neurasthenic parents, well nourished, withal hysterical and marked on the body with stigmata.

From her youth up she had drunk large quantities of black unsweetened coffee, taking a litre daily. No unpleasant effect was noticed until February 22nd, 1899, when at five in the morning she was seized with migraine, on her return from a dance. She took two doses of antipyrin (calculated to be from two to three grammes) and lay down to sleep. Half-an-hour afterwards, finding sleep did not come to her, she ascribed her wakefulness to having missed her ordinary drink of coffee before lying down. Very soon she felt an intense pruritus of the skin, and soon afterwards an erythematous rash appeared. Bullæ appeared on the face, dorsal surfaces of the wrists, and chest. Coincident with this was profuse lachrymation. She sat up in bed, but on attempting to rise she fell on the carpet. The maid, coming into her room at midday, found her semi-comatose, and did not rouse her.

At two o'clock in the evening Dr. Pappillon found the patient covered with a bullous rash, such as sometimes follows antipyrin. When roused from her stupor the patient appeared violently agitated. Her limbs were trembling rapidly in oscillatory movements, and a slight nystagmus was present, which, however, she was able to control by an effort of the will, the reflexes were exaggerated, epileptiform movements took place, her lips quivered, and she talked incessantly.

She was given a cup of strong, well-sweetened black coffee with some bread and butter, which she ate with relish, and she quickly regained her normal state. The rest of the day was passed as usual: she took no coffee on going to bed; sleeplessness and trembling returned, and on taking half a cup of coffee she immediately became quiet, and towards morning she slept for two hours.

The patient was now put on sweetened coffee, and the quantity gradually lessened; in 12 days it was wholly discontinued, and all the unpleasant symptoms disappeared.

The second case was that of a man, æt. 35, who visited the out-patient department of the Lariboisière

Hospital. He was a great smoker, but in no way nervous. He had called to consult the author for pseudo-anginal pains, which disappeared on his discontinuing the use of tobacco. But to the abuse of tobacco succeeded the abuse of coffee: Coffee was his stimulant; black coffee in the morning, coffee after each meal, without counting one or two cups in the middle of the day and at bedtime; the cup of coffee replaced his pipe. Coffee became necessary for the efficient discharge of his clerical duties, and he increased the number of cups and their frequency. At the beginning of October he suddenly stopped the use of the coffee, with the immediate supervention of migraine. He sent a servant to a chemist for a remedy, who returned with antipyrin powders (about one gramme in each). The patient took four powders within a short time, and very soon afterwards was covered with a violet-coloured and very itchy rash. When seen the rash had in parts become converted into bullæ; the limbs were all trembling; the patient was very greatly excited, and very talkative. A large glass of strong black coffee was at once given, with the effect of calming the patient: and on administering a second all the unpleasant symptoms passed away completely.

The after-treatment consisted in a gradual diminution of the amount of coffee taken daily, until he finally discontinued its use.

From investigations, carried out at the Dispensary of the Eighteenth Arrondissement, the author has found that the infants of mothers who affect excess in the matter of coffee are intolerant of antipyrin.

He concludes that (1) coffee acts as does alcohol on the nervous system, (2) that antipyrin is contra-indicated in those who use coffee to excess.

TREATMENT OF SCARLATINA BY ARSENIC.

The treatment of scarlatina by arsenic, introduced in 1896 by M. Sperensky (*La Médecine Moderne*), has, during a recent epidemic of the disease, been tested by M. Semtchewko. The epidemic was of a serious type, the cases were complicated ones, and some cases of diphtheria occurred. Prior to the use of arsenic some deaths took place, and determining to change his treatment M. Semtchewko gave arsenic a trial. He prescribed it as a curative agent to fifty-two children, and as a prophylactic in ninety-three cases. Under the treatment the fever did not reach such a high temperature as in the other cases, and all the characteristics of the disease were of a distinctly more favourable character.

The mortality of those treated with the drug was 17.5 per cent., and in the same district the mortality of those not so treated reached 39.10 per cent.

In a former epidemic in the same locality, which is not in a proper sanitary condition, the death-rate reached 52 per cent. He considers that the drug simply acts by augmenting the resisting power of the economy to the toxin of the disease. Dr. Bryan, of Leicester, recommended arsenic as a prophylactic to scarlatina in 1882, as did Dr. Walford of Finchley.

MILK FEEDING IN DIABETES.

MM. Wirtenitz and Strasser again recommend milk as the exclusive diet for diabetic patients. A glass of milk should be taken every hour until three litres are consumed. From their record of seven successful cases under this treatment (*La Médecine Moderne*) they find that within forty-eight hours the glycosuria wholly disappears, or, at least, is greatly lessened. The best results are obtained in young subjects—elderly obese patients, and those in whom the disease follows an injury, are not promising cases. The cases treated when put on a mixed amylaceous diet had no return of the glycosuria.

TREATMENT OF LEUCORRHOEA.

Dr. Landau (*Deut. Med. Woch.*) recommends the

use of yeast in the treatment of leucorrhœa, due to the presence of the gonococcus. He employed this treatment in more than 48 cases, in the great majority of these cases the discharge ceased after two applications. Landau used yeast cultivation liquid, and injected this to 20 cubic centimetres into the vagina.

On introducing a medicated tampon, which he kept in place for 24 hours; two patients complained that it gave them a painful burning sensation; none of the other cases found any unpleasant effect.

He considers that the effect is produced (1) by the expulsion of the microbes producing the leucorrhœa by a mechanical action due to the increase of volume of the yeast; (2) by the destruction of the nutritive substance necessary for the pathogenic microbes; (3) by the therapeutic action of the yeast and its products.

SUPPURATION OF THE PANCREAS.

M. Guinard (*Société de Chirurgie*) made a report on the successful treatment by M. J. L. Faure of suppuration of the pancreas. The patient, a man, æt. 22, suffered violent epigastric pains, his pulse was frequent, and he vomited incessantly. A laparotomy revealed the abscess. A fistula marks the position of the incision.

ZINOL.

Zinol (*Corriere di Medicina*) is a mixture of one part of acetate of zinc and four parts of the sulpho-lactate of alumina.

A solution of 1 to 3 grammes in a litre of water is recommended as an injection in gonorrhœa.

COCAIDINA.

Signor Schaefer (*Corriere di Medicina*) reports the discovery of a new alkaloid in the leaf of the coca, to which, from its similarity to cocaine, he has given the name *cocaidina*. Its fusion point is higher than that of cocaine, and it is less soluble in ether and petroleum. It forms crystallisable salts which are soluble in water and alcohol. It has anæsthetic properties, but their duration is not so permanent as those of cocaine.

CAKODYLATE OF SODIUM.

Dr. G. Rénaut warmly recommends the kakodylate of sodium (*Corriere di Medicina*) as the most suitable salt for the administration of arsenic in phthisical cases. Its tonic effects are well marked; it does not produce gastric irritation. The dose is from 12 to 24 centigrammes, but a single dose of 1 gramme has been given without unpleasant effects. In cases of pulmonary trouble, Dr. Rénaut prefers to give the drug by the rectum or by hypodermic injection, the dose by this latter method being from 0.003 to 0.06 grammes in the twenty-four hours; the medicine should be given for eight consecutive days and then left off for a week, then the administration is to be recommenced.

He claims that the effect of the drug are more satisfactory are produced by Fowler's solution, and its rectal injection produces no irritation of the mucous membrane of the bowel.

Arsenicum forms with alcohol radicles compounds. Some in the methyl and some in the ethyl series, which have been examined; of these, one of the best known is arsenic—dimethyl, or cakodyl. Considerable interest attaches to it as the starting point of the inquiries into the organo-metallic bodies. Cakodyl was obtained by Bunsen by the action of granulated zinc on its chloride. It has the formula $2(AsC_2H_5)_3$. Cakodylic acid has the formula, $H(AsC_2H_5)_3O_3$, and the cakodylate of sodium, $Na(AsC_2H_5)_3O_3$. Cakodylic acid crystallises in oblique equilateral prisms, which are soluble in water and in alcohol. It is remarkable that it possesses little or no poisonous action upon the animal system, seven grains of it

having been injected into the blood of the rabbit without producing marked effect. It is a weak acid, and decomposes the carbonates slowly.

DORMIOL.

Huchs (*Corriere di Medicina*) has given the name "dormiol" to a compound of the hydrate of chloral and the hydrate of amyl, which he recommends as a good hypnotic. It is an oily liquid, colourless, smelling of camphor, slightly soluble in water, soluble in alcohol, in ether, and the oil acids. The dose is from fifty centigrammes to one gramme.

ASPIRINA.

This substance is obtained (*Corriere di Medicina*) by the action of anhydrous acetic acid on salicylic acid. It is recommended as a good remedy for rheumatism. It occurs in the form of a white, finely-crystalline powder, slightly soluble in warm water, and in alcohol and ether. The gastric secretion does not decompose the substance, but the pancreatic secretion liberates the salicylic acid. It is given in gramme doses twice or three times a day.

GALLOFORMINA.

Galloformina (*Corriere di Medicina*) is obtained by the action of gallic acid on tetraminescamethylene. It crystallises in fine needle-like masses, slightly soluble in water, ether and alcohol. Taken internally it acts as an antiseptic acid from its property of giving off formaldehyde in the presence of the intestinal juices.

OXAFOR.

Oxafor is the name given to a 50 per cent. solution of oxygen in alcohol (*Corriere di Medicina*). It is strongly recommended as a remedy for dyspnoea. Rumpel introduced the remedy for the laboured dyspnoea caused by cardiac disease, emphysema, bronchitis, and consumption.

It is given in doses of 50 centigrammes to 2 grammes in the 24 hours.

ANTIMELLINA.

Antimellina is the name given by Boersch (*Corriere di Medicina*) to a glucoside obtained from the fruit of the *Syzygium Jambolanum*, which is said to give good results in the treatment of diabetes mellitus.

A NOTE

ON THE USE OF THE

ESSENTIAL OILS FOR INHALATION.

By LENNOX BROWNE, F.R.C.S.Ed., &c.,

Consulting Surgeon to the Central London Hospital for Diseases of the Throat, Ear, and Nose.

ALL that emanates from Dr. Robert Lee on the subject of inhalation is interesting, and in offering a few words thereon I do not for a moment doubt his facts. I venture, however, to think that the question of the true evaporability of the essential oils to which he draws attention in the last issue of the MEDICAL PRESS & CIRCULAR was settled and systematised nearly thirty years ago with the publication in 1872 of the first edition of the "Throat Hospital Pharmacopœia," in the preparation of which I had the honour to take an active share, being assisted, perhaps I should rather say guided, by so able a chemist as Mr. Lloyd Bullock, who is still alive at a venerable age.

The experiments with essential oils were much more detailed and accurate than can appear in a Pharmacopœia. We found that for all practical purposes the majority of the oils—all, indeed, that were of therapeutic value—were best prepared for the purpose of inhalation by suspension in water with a medium of light carbonate of magnesia, for the most part in the proportion of half a grain to each drop of

oil. But it may be mentioned that there was considerable variation in the amount of essential oil that can be comfortably inhaled, for while the prescribed dose of oil of Cubebs was six minims for each inhalation, that of Cajeput was only one. On the other hand, that of Calamus aromaticus (sweet flag), though by no means irritating to the olfactory sense, was found to be almost too powerful a stimulant to the respiratory tract, even in the dose of half a drop in a pint of hot water. All these oils, and many others, were evaporable when mixed with water at a temperature of from 140 to 160 degs. F.

Another point of interest was that the oil of Hops did not prove to be the sedative we expected, and in later editions of the "Pharmacopœia" Lupuline was substituted. This is, however, inferior to the official Conium inhalation. Dr. Robert Lee would appear to advocate a more general employment of these essential oils for inhalation. With all respect, I am of opinion that the almost complete disuse into which they have fallen is more than justified; since the inhalation of steam, however modified its relaxing effects may be by the addition of stimulating ingredients, should be restricted to those patients who from the nature of their illness are confined to the house; nor is the risk of catching cold insured against by the precaution of Morell Mackenzie that "the patient should not go out of doors for half-an-hour after inhaling." For those pursuing their daily vocation oily or spirituous solution of menthol, creasote, guaiacol, iodoform preparations, &c., employed as sprays under air pressure, are now generally preferred.

Clinical Records.

VICTORIA HOSPITAL FOR SICK CHILDREN, CHELSEA.

A Case of Inward Displacement of the Lower Epiphysis of the Humerus. (a)

Under the care of Mr. D'ARCY POWER, M.B.Oxon, F.R.C.S., &c.,
Surgeon to the Hospital.

THIS is a case of inward displacement of the lower epiphysis of the humerus, skiagram whereof I am enabled to hand round. The patient is a girl, æt. 6, who fell upon her left arm in September, 1899. It was impossible to obtain details of the accident, which happened in Cornwall, but the arm had been kept in splints for six weeks. She was admitted to the Victoria Hospital for Sick Children on January 1st, 1900, on account of a deformity of the elbow. The arm was in a state of cubitus varus, that is to say, the long axis was directed inwards at the elbow, but there was neither shortening nor wasting. The movements of flexion, extension, pronation and supination, were unaffected, and the patient only complained of a little pain over the projecting external condyle. I hesitated therefore to perform any operation, thinking that if I did so the last state of the arm might possibly be much worse than the first. The skiagram shows that it would be quite easy to chisel away the projecting angle of the shaft of the humerus. I think, however, that it would be better to do this when the developmental processes at the elbow have been completed. I may point out that the case belongs to a very obscure class of injuries to the elbow, whose exact nature is now only becoming known by the application of the Röntgen rays. The skiagram shows that the separation of the lower epiphysis of the humerus had been subperiosteal, and had resulted in a shifting of the whole epiphysis towards the inner side. The displacement has led to the external condyle of the humerus losing its cartilaginous covering; whilst the cavity of the olecranon has its long axis oblique instead

(a) Case shown at the Harveian Society, February 1st, 1900.

of vertical. The epiphysis appears to be fixed in its new position by an ossification of the periosteum which was probably injured at the time of the accident, and by an increased width of the internal condyle which serves to support the epiphysis in its new position.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, FEBRUARY 9th, 1900.

SIR R. DOUGLAS POWELL, Bt., President, in the Chair.

FATAL HÆMO-PNEUMOTHORAX OF UNEXPLAINED ORIGIN.

DR ROLLESTON related the case of a male, æt. 21, whose past history showed nothing but dyspepsia. After some diarrhoea and abdominal pain, lasting two days, he was suddenly seized with agonising pain in the right hypochondrium, radiating to the umbilicus and right shoulder. On admission 24 hours later to St. George's Hospital he appeared moribund, but subsequently he rallied, and next day had signs of right pneumothorax, with considerable displacement of the heart. Some doubt existed as to whether the collection of gas was above or below the diaphragm. Paracentesis of the right side of the chest brought out blood and some air at considerable pressure. Death occurred from exhaustion and bronchitis eight days after the onset of acute pain. At the autopsy the right pleura contained 60 ozs. of blood. The thoracic wall was opened under water, and no air was found in the right pleura. Except for collapse the lung was healthy. Microscopically there was no evidence of tubercle or pleurisy. There were no signs of hæmophilia, scurvy, cirrhosis of the liver, aneurysm, or traumatism. No cause for the blood or for the gas in the pleura was forthcoming.

Dr. NEWTON PITT reported a case of

RAPIDLY FATAL HÆMOPNEUMOTHORAX, WHICH WAS APPARENTLY DUE TO THE RUPTURE OF AN EMPHYSEMATOUS VESICLE.

The patient was a young man, æt. 18, who had always enjoyed good health. On September 15th he had a sore throat, vomited three times, and had his bowels opened twice, but he was only confined to the house for a day. He went out for a walk at 4 p.m. on Sunday the 19th, but had to return on account of pain in the right chest and shoulder. This increased during the night, and at 4 a.m. he was extremely ill, with intense pain and collapse. At 8 a.m. he was cold, pulseless, and had vomited. When seen in consultation with Dr. Stokes, of Highbury, at 3 p.m., there was evidence of an acute pneumothorax, with dulness over the right base, the heart was pushed over, so that the impulse was 2 ins. to the left of the nipple line. The heart rate was 150; there was no pulse at the wrist. In order to relieve the intense pressure, a Southey's tube was inserted in the sixth space in the axilla, with the intention of allowing the fluid and gas to gradually escape into a large antiseptic dressing, which is the most satisfactory method of dealing with a pneumothorax. It caused surprise to see some ounces of blood escape, after which the tube became blocked with clot. It was reinserted further forwards, when blood and air bubbled out. The pain and distress increased, and were not at all relieved by the operation; it was therefore concluded that the hæmorrhage was continuing. An injection of morphia was given to quiet him, with the intention of again attempting to relieve the tension next day, should the hæmorrhage cease. He died, however, the same night at 8 p.m. At the inspection, the right pleura was found to contain eight pints of fluid blood, with as much clot as filled the hands three times, and also a considerable quantity of air. The lung was tightly compressed, the heart pushed over to the left. A careful examination was made for the source of the air and blood. No perforations or injuries could be found, nor was there any trace of a tuberculous, inflammatory or

necrotic lesion in the lung. The heart, aorta, pleura, and lung were normal, with the exception that there was an emphysematous bulla, about half an inch in size, torn open, situated near the apex of the lung, and attached to this was a ruptured adhesion, the size of a knitting needle, from which the blood may have come, but no aneurysmal pouch or large patent vessel was visible. The lesion is undescribed in medical works. Punctured wounds of the lung and chest might produce this condition, which it may be supposed must also occasionally result from any acute process, which destroyed both the wall of a blood vessel, and also the lung tissue near the pleura, such as a caseous pneumonia, gangrene or abscess; but cases due to these causes do not appear to have been recorded with the exception of a reference by Sausser.

In reply to the President, Dr. PITT mentioned that there were 8 pints of fluid blood and two or three hand-fuls of clots.

Dr. HINGSTON FOX referred to the case of a man, æt. 44, particularly healthy and robust, who developed symptoms of pleural effusion with fever. He was tapped on the tenth day, when 14 ounces of dark blood came away. Three days later, signs of pneumothorax having supervened, the operation was repeated, and 45 ounces of blood came away along with much air. The patient had since made a good recovery. No family or personal history of phthisis. Discussing the etiology, he remarked that the patient had been employed in a very ill-ventilated office with defective drains, and three of the nine employees had broken down within six months, the other two with hæmoptysis.

SIR DYCE DUCKWORTH thought that the sequence of events in these cases was rupture of the lung, with ordinary pneumothorax, followed by hæmorrhage, and behind the whole of the phenomena was tuberculosis.

Dr. S. WEST recalled a curious case of pyo-pneumothorax in which pus was evacuated, and this was followed by hæmoptysis. At the autopsy they found an old tuberculous cavity in which an aneurism had broken, and as the cavity also communicated with the pleura the blood escaped both ways.

Dr. PERCY KIDD asked whether the bacillus capsulatus aerogenes could be excluded, remarking that in neither of the cases was there any trace of tuberculosis.

The PRESIDENT said that the question of the precedence of the pneumothorax and hæmorrhage required to be cleared up. He had once made experiments to see how much fluid could be pumped into the chest, and the most was six or seven pints. He said it was curious that the blood remained liquid in the presence of air.

Dr. ROLLESTON, in reply, said his patient had had diarrhoea and abdominal pain which might be thought indicative of a toxic influence. He did not think that the bacillus capsulatus aerogenes would be likely to die out, so that if it produced air during life it would probably produce much more after death.

Dr. NEWTON PITT, in reply, said the only symptoms that preceded the acute attack were sore throat and diarrhoea, three days before, but he was unable to affirm any connection between them and the attack. He had expected to find tuberculous lesions, but had failed to do so. With reference to the quantity of blood he recalled a case in which seven pints of fluid had been removed from the pleura, and on looking up the records he had found cases in which as much as eleven and twelve pints were said to have been removed.

MEERS, J. J. PERKINS AND C. S. WALLACE ON A CASE OF PERFORATING DUODENAL ULCER—OPERATION—RECOVERY.

Patient, a male, æt. 52, was admitted to St. Thomas's Hospital complaining of epigastric pain of three days' duration, with a violent exacerbation six hours before. There had been no vomiting. The abdomen was tense, rigid, almost motionless, with complete absence of liver dullness in the nipple line. Ten hours after the onset of acute pain the abdomen was opened through the right rectus; the age and sex of the patient, the history and the absence of liver dullness making it probable that a duodenal ulcer had perforated. A perforation was discovered at the

junction of the first and second parts of the duodenum; the edges were clean cut and showed no sign of induration. The intestines showed some points of injection, but there were no very evident signs of peritonitis. The perforation was closed with two rows of sutures, and the abdomen cleaned with evisceration and flushing with sterilised water. The abdominal opening was closed with silkworm gut sutures and by a row of buried sutures. A gauze wick was left in passing down to the seat of ulcer without further drainage. Convalescence was uneventful—the plug was removed on the second day, the bowels were opened by enema on the third day, and milk first given by the mouth on the tenth day. Operation on these cases is favoured by the site of the perforating ulcer, which in twenty-nine out of thirty-seven reported cases was on the anterior wall. The condition of the abdomen when seen early is that of early peritonitis, rigidity, contraction, and loss of movement. Paroxysmal exacerbations of pain due to peristalsis increase the resemblance to colic. The complete absence of the liver dullness internal to the nipple line is to be taken as a guide. In locating the perforation to the duodenum the previous history of the patient is an aid in perhaps half the cases, though perforation in many cases occurs without the slightest previous warning. The site of the pain caused by the perforation at its onset is of great help though occasionally misleading. From statistics it is clear that duodenal can hardly be diagnosed from gastric ulcer. The resulting peritonitis is sometimes diffuse from the first, but often the great omentum shields the mass of the intestines and directs the extravasation to the pelvis. The right lobe of the liver on its upper aspect and the parts round the duodenum are especial sites of the inflammation in these cases, and special care should be taken in cleansing these regions. The whole abdomen, however, should be irrigated, the intestines being turned out and themselves flushed. Drainage is not required, but a gauze wick should be left in the abdominal wound running down to the site of the ulcer. The collapse which is a marked feature of these perforations high up should be met by saline infusion, and operation proceeded with as quickly as possible.

Mr. BATTLE remarked that the diagnosis was difficult and the treatment somewhat delicate. He had seen more than one case in which the perforation was either not found or was treated unsuccessfully, and he referred to a case at St. Thomas's, thought to be duodenal, which turned out to be gastric.

Mr. BARKER challenged the author's statement that the proper treatment of cases of this kind was evisceration and irrigation. He admitted that in years gone by he had followed that practice, but with greater experience he, in common with many other surgeons, had abandoned it. Speaking with considerable experience of perforating ulcers of the stomach, he had come to the conclusion that the less one meddled with the abdomen the better. He remarked that the peritoneum could dispose of a great deal of septic matter, and all that was necessary was to reduce the dose of poison within the limits of its action.

Mr. PRACE GOULD criticised Mr. Barker's assumption that the fluid effused into the peritoneum was septic, and he suggested that this material was very irritating on account of its extreme acidity, and in virtue of its effect on the intestine it might favour secondary infection through the damaged walls. He thought it was best to remove the fluid lest it should become septic.

Dr. POYNTON said that during two years at St. Mary's Hospital he had made necropsies on no less than eight such cases, and he had seen several other cases, diagnosed as such, in the wards. Six of the eight were in males between 28 and 55 years of age. One case showed no symptoms at all during life. All the ulcers except one were extremely chronic, and all but one had made their way through the entire thickness of the intestine and had formed a new floor by adhesions. There was usually a long history of dyspepsia and pain. The ulcers were all situated in the first part of the duodenum, sometimes in front, sometimes behind, and with one exception, were single. He thought the chronic nature of these ulcers explained the important features of the disease; the severity and prolonged

duration of the pain. The diagnosis during life was so uncertain that one hesitated to advise morphia injections. Medical treatment required to be persevered in to afford relief. He remarked that great dilatation of the stomach might be present apart from stricture. He remarked that the association of duodenal ulcer with chronic renal disease was distinctly strengthened by his series, in five of them the kidneys being cirrhotic and containing cysts. He did not see how the renal lesion could cause the ulcer and suggested that there was some common underlying cause.

Mr. CHARTERS SYMONDS agreed that evisceration was dangerous and, moreover, unnecessary. Between that practice and Mr. Barker's practice of merely mopping out the fluid there was a middle course, flushing and sponging, which he thought was the best plan. In a case of his own seen six hours after perforation, the man recovered without drainage. He referred to two cases of a duodenal ulcer in which he divided the duodenum for the relief of gastric dilatation. One patient had recovered, but the other had died from hæmorrhage.

Dr. POYNTON, in reply, remarked that the absence of adhesions was remarkable in perforating ulcers of the duodenum as compared with the non-perforating ones.

Mr. T. H. KELLOCK on a case of

STRICTURE OF THE SMALL INTESTINE FOLLOWING STRANGULATED HERNIA.

The patient, a youth, æt. 16, was admitted to the Middlesex Hospital for strangulated left inguinal hernia. Two years previously he had been operated on at the West London Hospital for hydrocele in connection with an imperfectly descended testis on this side. He had had a hernia some time, but he had always been able to reduce it easily; he had not worn a truss. He had strained himself on the morning of admission, the hernia came down and he could not reduce it. On admission he was a good deal collapsed and vomiting; the swelling in the left inguinal region was as large as an orange. At the operation there was no fluid in the sac, which contained a piece of discoloured omentum and about 4½ inches of small intestine, the latter was very dark in colour, but still retained a shiny appearance, and after the stricture had been divided and a little more intestine drawn down the colour improved a little; the intestine was therefore returned to the abdomen, and then the testicle was found lying internal to and behind the hernial sac. It was surrounded by a tunica vaginalis, which contained a good deal of clear fluid, but which did not communicate either with the sac of the hernia or the general peritoneal cavity. The testicle and tunica vaginalis were removed, and the operation completed by closing the inguinal canal and skin by sutures. For three weeks the patient did well, and the wound healed by first intention. Then he began to suffer from slight pain in the abdomen, some vomiting, and occasional slight distension of the abdomen. On one occasion he had a rigor lasting fifteen minutes, when the temperature rose to 102.2, but with this exception the temperature was normal throughout. By the use of medicines and enemata these symptoms were relieved, and the patient was sent to a convalescent home 5½ weeks after the operation. The bowels were then acting regularly, and he was free from pain. During his stay of three weeks at the Home he had occasional pain in abdomen, constipation, vomiting, and some distension of the abdomen, and these symptoms continued more or less till his readmission to the hospital six weeks after his discharge. They were always relieved by aperient medicines, but tended to increase in severity rather than decrease. He was readmitted complaining of great pain in the abdomen, vomiting, and profuse diarrhoea. For a few days he improved under treatment, but then the symptoms returned, so the abdomen was opened in the middle line below the umbilicus. A coil of small intestine was found in the right iliac fossa, which was considerably constricted; the gut above it was hypertrophied and dilated, that below of about normal size, a piece of omentum containing rather large vessels was attached to the front of the coil. This piece of omentum was ligatured and divided, and a lateral

anastomosis made by Halsted's method uniting the intestine above and below the strictured portion. The abdominal wound was then completely closed. For two or three days the patient made fair progress, but then the abdomen became distended and tender, showing evident signs of general peritonitis; vomiting recommenced and the general condition became very bad. The wound was reopened and a drainage tube inserted leading down to the seat of operation. Death occurred about fifteen hours subsequently. At the post-mortem examination general peritonitis was found, the anastomosis was found to be firm and watertight, with a good opening between the portions of blood united. There was gangrene and perforation of the coil of small intestine which had been put out of action by the anastomosis and the mesentery attached to it was hard and puckered. In this portion a stricture was found extending about half an inch in the long axis of the bowel and almost completely obstructing the lumen. Attention was called to the rarity of stricture of the small intestine to a degree calling for operative treatment, as a result of strangulated hernia. The association of inguinal hernia and imperfectly descended testicle is common, but in this case the hernia was not of the congenital variety as the tunica vaginalis was separate from the sac of the hernia. The bowel was returned to the abdomen at the first operation rather than resected, as it was thought it would recover, more especially in a patient of this age. At the second operation the chief interest was in the piece of omentum which was adherent to the bowel; it was noticed at the time that this contained large vessels, but the importance of this fact was not recognised till later. What had apparently occurred was that at the time of the strangulation this mesentery had been severely constricted, and after the return of the bowel it had become adherent to the omentum, and, nourished in this way and not by means of its mesentery, the division of this piece of omentum had cut off the blood supply of the coil of intestine, which had therefore become gangrenous and perforated, setting up a general and fatal peritonitis. It was disappointing that such an unlooked-for occurrence should prove fatal in a case which otherwise promised so favourably.

Mr. BATTLE said that during the last two years he had had four cases of intestinal stricture either secondary to inflammatory changes or of a fibrous character. One was a case of chronic obstruction of the small intestine due to pressure of caseous glands, the patient recovering after lateral anastomosis. The second patient had been operated upon for appendicular disease two years before and came with acute intestinal obstruction. He found considerable cicatricial contraction about the ileum, and he performed enteroplasty unsuccessfully. Two years ago he performed abdominal section on a man of 60 with intestinal obstruction. He found cicatricial contraction of the small intestine, several coils being adherent and twisted. He undid the twist, and the man recovered, but eighteen months later he came in again with obstruction. This time he performed lateral anastomosis, putting three or four feet of intestine out of circuit.

Mr. CHARTERS SYMONDS commented on the author's remark as to the blood supply of the strangulated loop being derived from the omentum, and asked whether the gangrene was limited to the part above the anastomosis or whether it involved the stricture and the part below.

Mr. KELLOCK, in reply, said that nearly the whole loop of bowel below the anastomosis was of a dark colour with a perforation at its apex. The piece of omentum he had ligatured was stretched over this piece of bowel and certainly appeared to furnish its blood supply, its vessels being distinctly larger than usual.

AFTER much palaver and negotiation, the project of an amalgamating the Medical Defence Union and the Medical Protection Society appears to have been definitely dropped. In a sense this is perhaps to be regretted, but possibly a little competition and rivalry may act as useful stimuli here as in other walks of life.

ROYAL ACADEMY OF MEDICINE IN IRELAND. SECTION OF PATHOLOGY.

MEETING HELD FRIDAY, JANUARY 12TH, 1900.

The President, Professor A. C. O'SULLIVAN, M.D.,
in the Chair.

FRACURED PELVIS.

PROFESSOR E. H. BENNETT showed an united fracture of the pelvis involving the brim or inlet of the true pelvis the lines of fracture being placed in the oblique diameters of the pelvis, and obliquely through the sacrum. He presented this specimen to establish the fact that patients even suffering so grave an injury may recover. He had dealt with such a case in the living also. He showed a specimen of this form of fracture that was fatal. He showed two specimens of the form of injury which results in the displacement of the head of the femur, either incompletely or completely, inwards through the acetabulum into the pelvis. Referring to the double vertical fracture of the pelvis, he exhibited an enlargement of Voilemier's plate of this lesion, and stated that in three cases that had come under his care recovery had been complete.

Mr. H. G. CROLY said he had three cases to relate. The first was that of a man thrown off a dray, and the wheels of it went over the pelvis. He was found collapsed, with the symptoms of laceration of the urinary bladder. After death he found the anterior part of the bladder torn, and the os pubis fractured. The specimen is in the Museum of the College of Surgeons. The second case was that of a gentleman whose horse fell and rolled over him. On catching hold of the crest of the ilium he could rock the ilium backwards and forwards. The patient got phlebitis of the veins of the lower extremity, but ultimately recovered. The last case occurred in a lady who fell on her coccyx. It was fractured, as could be diagnosed by inserting a finger into the rectum. By a push backwards the bone went into its place.

Professor BENNETT replied.

EPIPHYSARY FRACTURE OF LONG BONES.

Dr. KNOTT showed a number of specimens of epiphysary fractures of long bones.

Professor BENNETT observed that in cases of compound separation of the lower epiphysis of the humerus the synovial cavity remained unopened, observed that the periosteum of the humerus was practically inserted into the epiphysary cartilage. The lesion consequently was a dislocation of the lower end of the diaphysis, not of the epiphysis, and this part was displaced out of its periosteum like a finger out of its glove, so that there was interposed between the synovial membrane and this diaphysis the tough periosteum of the bone, and the synovial membrane thereby escaped being opened. In dealing with a case of compound separation of this epiphysis in which the brachial artery had been torn, the question arose whether he should amputate the limb at once in anticipation of profuse suppuration. It was urged, however, that a suppurating wound would do the elbow no harm, and that they might save the limb which proved to be the case.

Dr. KNOTT, in reply, said that having formerly seen the ligaments of the elbow-joint only in adult subjects, he always found the anterior and posterior ligaments attached above their respective fossae. The specimen which he had shown them that evening showed the attachment of the anterior and posterior ligaments of the elbow-joint just at the margin of the articular surfaces so settled the question.

SUDDEN DEATH FROM OCCLUSION OF PULMONARY ARTERY.

The PRESIDENT related the case of a woman, *et. 48*, admitted to Sir P. Dun's Hospital for umbilical hernia, on December 4th, and who died suddenly on December 17th, no operative treatment having been employed. The symptoms preceding death were complete unconsciousness, heavy stertorous breathing, contracted pupils, slight frothing at the lips, which were open; the tongue was quite colourless, the face of a dull, leaden colour

the pulse imperceptible, and the heard sounds barely audible. Death took place in about five minutes. At the post-mortem examination an embolus was found plugging the pulmonary artery at its bifurcation, consisting of a clot 7 ins. long, $\frac{1}{2}$ in. wide at one end and tapering to $\frac{1}{4}$ in. at the other, bent three times upon itself so as to form an S. A tumour was found in the pelvis, which consisted of the uterus, distended by a large myoma growing in the cavity of the uterus, and completely filling it. This pressed upon both external iliac veins, and caused thrombosis, with œdema of both legs. The thrombosis, which caused death, probably came from the left long saphena vein.

Mr. H. G. CROLY thought that if intra-pelvic tumours which were so common, could produce this effect of sending a clot up to the pulmonary artery, it was a remarkable thing that death was not more common from this cause in such cases.

Prof. E. J. McWEENEY inquired as to the condition of the portion of lung supplied by the occluded branch of the pulmonary artery. Was it infarcted with blood or obviously anæmic, or in what condition was it? As far as his reading went he believed the enormous length of the embolus to be unique.

The PRESIDENT, in reply, said that the entire pulmonary artery was blocked, as the clot went into the left branch, and blocked the right by projecting into the main trunk across the opening. He had omitted to mention that there was great œdema of the legs, and the superficial veins was tortuous and varicose. He had seen recently in Thoma's Pathology a picture of a case almost identical with what this must have been when lying in the pulmonary artery. The clot, however, was twisted twice, and lay in the pulmonary artery.

EXHIBITS.

Mr. HENRY GRAY CROLY showed—(a) larynx and trachea of child, showing œdema of glottis with tracheotomy tube *in situ*; (b) unusual foreign body—shawl-pin with large glass bead—removed from the male urethra.

Dr. KNOTT exhibited a series of specimens of a hitherto undescribed fracture of the patella.

The SECRETARY (Prof. McWeeney) — (a) a series of cultures to illustrate the effect of certain variations of the nutrient medium on the growth of the typhoid bacillus; (b) sections to illustrate certain points in the morbid histology of a case of extensive tuberculous disease of the intestines, followed by acute miliary tuberculosis of the liver.

The Section then adjourned.

OBSTETRICAL SOCIETY.

MEETING HELD WEDNESDAY, FEBRUARY 7TH, 1900.

Mr. ALBAN DORAN, F.R.C.S., President, in the Chair.

Dr. AMAND ROUTH showed a specimen of "Homologous Female Twins," united along the anterior and lateral aspects, from the manubrium sterni to the umbilicus. They belonged to the group Emprothozygosis, and to the sub-group Thoracopagus. They weighed 9½ lbs., and had a single umbilical cord and placenta. There was one thoracic cavity, with four lungs, each in its own sac, and two hearts, united by a band at their bases, lying in a single pericardial sac. There was a single abdominal cavity and one peritoneal sac. The livers were united, and below the fused arch were two complete stomachs, uniting by two duodena, and passing thence into a single jejunum, which opened into a large pouch, 3½ inches across. From this, two pieces of small intestines issued, ending in a complete cæcum and appendix vermiformis, and were continued by large intestine to a patent anus on each side. There were two kidneys, ureters, and adrenals, and one spleen, in each foetus, and the pelvic organs were normal.

The twins were of thirty-two-and-a-half weeks of intra-uterine gestation, and were stillborn. Their birth, as described by Dr. Abbott, who had attended the confinement, was a difficult one. A head presented, and was delayed after partially passing the vulva, and an

examination proved that another head was impacted in the pelvis, pressing against the thorax of the first child. With difficulty the arms and shoulders of the first child were delivered, and the fact that the twins were united was then discovered.

Finally, they were delivered by traction on the head and arms of this first child, with no more damage to the mother than a torn perineum, which healed well. The mother convalesced normally.

ANNUAL MEETING.

The PRESIDENT then delivered the usual address, and the business of the annual meeting was transacted.

HARVEIAN SOCIETY OF LONDON.

MEETING HELD THURSDAY, FEBRUARY 1ST, 1900.

H. E. JULES, F.R.C.S., President, in the Chair.

Mr. D'ARCY POWER read notes of a case of Inward Displacement of the Lower Epiphysis, which will be found under "Clinical Records."

Mr. JACKSON CLARKE demonstrated the method he employs for supporting the spine in "carries of the cervical and upper dorsal regions," as applied to a patient, æt. 8, in whom the disease was situated about the fifth and sixth dorsal vertebrae. The child had been treated in the out-patient department for over a year and had greatly gained in general health, and the local spinal trouble had much improved. The support used was a form of Chance's splint furnished with an occipital horse-shoe shaped piece to which was added a chin-strap. The principle of antero-posterior support was approved by the late Sir John Erichsen in the form of Taylor's splint, introduced in America in 1870. Mr. Clarke found that Chance's splint, introduced in London in 1850, was simpler and in some ways better. After a long and careful comparison with the various forms of corsets he had no hesitation in deciding in favour of the method of antero-superior support.

In reply to Mr. Drew Mr. CLARKE said that he had based his judgment on an extensive clinical experience.

Dr. HERBERT TILLEY showed two cases of "Chronic Frontal Sinus Empyema" in which the radical operation had been performed. In both cases the disease was bilateral, and relief was sought for nasal obstruction and profuse purulent discharge. He had operated on both sinuses in the female and, as yet, on one side only, in the male. Both patients were practically cured except the young man who still had a discharge from the left, untreated nostril. In neither case was headache a prominent symptom. In both cases the maxillary antra also contained pus. Dr. Herbert Tilley laid great stress on the importance of removing intranasal pathological conditions before proceeding to the external operation. His usual line of treatment was to remove the nasal polypi or unhealthy granulations from the region of the middle meatus and also, in all cases, the anterior half of the middle turbinate bone which was nearly always diseased in chronic cases, and formed an obstruction to free drainage from the frontal sinus. If the antrum contained pus it should be drained by the alveolar method. When the middle meatal and anterior ethmoidal regions were healthy then the external operation might be undertaken with every prospect of success. This consists in making an incision down to the bone along the minor third of the line of the eyebrow terminating just above the internal palpebral ligament. The anterior wall of the sinus was entirely removed if the sinus was only of moderate size, otherwise only a portion of the wall. The diseased mucous membrane is then thoroughly curetted and a large opening made into the nose (an enlargement of the wound free to nasal canal) which should be sufficient to admit the tip of the little finger passed up from the nose. A drainage tube is then inserted in cases where the sinus has not been entirely obliterated. The wound is closed at the end of the operation by one or two stitches, and the resulting scar, as in these cases, is hardly noticeable.

In reply to Mr. Power, Dr. TILLEY said that the

dangers of operative interference in this region were much minimised by careful preliminary study of and acquaintance with the anatomy of the parts involved, as the frontal sinus did not develop till seven years of age, and remained small till after puberty, such treatment as had been described would very rarely be called for in young people.

Dr. WHITFIELD showed a case of

ACNE VULGARIS, COMBINED WITH MARKED SEBORRHOIC ECZEMA.

This patient, a boy, *æt.* 16, was in the grocery trade and worked very late hours in hot rooms, but he stated that his general health had never suffered in any way. For about three years he had suffered from acne of the face; for about a year he had noticed that his head had become very scurfy and that red spots occasionally came out on his chest. During the last month the condition of the head and chest had become much more marked, and red spots had come out on his back and face. On examination one was at once struck by the presence of enormous numbers of comedones on the face, especially on the forehead and cheeks. Most of these were large and prominent, but few only were much inflamed, pustulation being present only in slight degree. The skin of the face was noticeably greasy, a condition which might be partly accounted for by insufficient washing, but was undoubtedly more than a mere accumulation. The whole of the scalp was covered with a very thick greasy scale, which extended downwards in a gyrate manner on to the left side of the forehead. Where the rash reached the forehead it was seen to be of a florid red colour with very defined outline and covered with a yellowish scale. On the chest and back a considerable number of comedones could be seen, without any inflammatory areola around them, and in addition to these was a number of discoid patches, varying in size from that of a small lentil to that of a sixpence. These patches could be traced from single follicular papules and, when they had extended centrifugally, they became bright red hyperæmic spots, without infiltration, but covered with an adherent and rather greasy scale. The condition thus strongly simulated psoriasis at the edge of the hairy margin of the scalp, and on the chest and back. There were, however, no other lesions on the knees and elbows, and the facts that the disease was associated with a general seborrhœic condition of the skin, and that these psoriasis-like spots took origin from small follicular papules would seem to justify the diagnosis of seborrhœic eczema. Some observers are inclined to identify seborrhœic eczema with psoriasis as one and the same disease, and I myself believe them to be distinct, and, while admitting that the differential diagnosis is occasionally very difficult, I see no reason for, therefore, believing them to be identical. I ordered the boy an ointment containing 2 per cent. of salicylic acid and 3 per cent. of sulphur, and if the disease does not yield to this I shall add some oil of cade to the ointment.

TACHYPNŒA IN ASSOCIATION WITH UPWARD DILATATION OF THE STOMACH.

The patient exhibited by Dr. W. EWART, an upholsterer, *æt.* 18, has suffered from infantile bronchitis and from habitual cough, and for four years from shortness of breath on exertion. She had recently been laid up in bed for three weeks with rapid breathing, orthopnœa, oppression across the sternum, and discomfort at the left thoracic base. On admission the suspicion that the case might be one of hysterical tachypnœa was not confirmed by the aspect or history. Scattered wheezes were heard in the chest, and the dyspnoea was genuine. The tachypnœa, which was not complicated with any increase of the pulse rate or of the depth of the respirations suggested the likelihood of upward dilatation of the stomach as a cause. This was also rendered probable by the patient's distension and oppression at the lower sternum and regurgitation of bitter tasting food after meals. On examination the stomach was found to be dilated upwards as far as the level of the fourth costal cartilage rising above the level of the cardiac apex which was in the normal situation. The tympanitic note encroached upon part of the cardiac dulness and replaced the dulness

of the left lobe of the liver. The chest did not present the usual signs of emphysema and subsequently gave amply respiratory movements as the patient recovered under appropriate gastric treatment. The tachypnœa was never extreme (53 per minute). On the day when the tachypnœa and respiratory distress were relieved a further examination showed that the upper boundary of the gastric resonance had returned to the normal level. Additional features of interest in the case were the liability to pseudo-rheumatic pains in the joints, the decayed condition of several of the teeth, and the presence of a tape-worm, which had been allowed to remain without treatment for the last four years.

Mr. SEFTON SEWILL said that a point of interest was raised by Dr. Ewart's paper, inasmuch as Professor Artrövy had some time ago described a bacillus constant in the pus of abscesses of dental origin, especially those of a chronic nature. This was named *B. gangrene pulpæ*, and Dr. Wm. Hunter in a paper before the Odontological Society had ascribed to its presence in the stomach several troublesome affections of that organ. The point was the importance of bringing the mouth into a thoroughly healthy state in all cases of disease of the stomach.

Mr. DOUGLAS DREW showed a case of large fibroadenoma of the breast.

The President and Drs. Herbert Tilley, Alfred Eddowes, A. Whitfield and Messrs. J. Jackson Clarke, Edmund Roughton d'Arcy Power, and Douglas Drew took part in the discussions which followed.

Dr. ALFRED EDDOWES showed (1) a rapidly recovering case of "Alopecia areata." The patient, a boy, *æt.* 16, had been treated by several medical men, but the disease had become nearly general and had been looked upon as almost hopeless. Thyroid extract was administered and lysol solution applied locally with the result that the hair was rapidly returning, of normal colour, and the boy was growing fast and improving in every way. Dr. Eddowes believed that the case was essentially leucoderma of hairy parts. (2) "Coccogenic sycois," which had begun on upper lip, apparently from infection by discharge from the nose, which latter had in turn been caused by discharge from sore eyes. He thought it would be almost useless to cure the sycois without treating the eyes. He had seen three cases of the kind in one afternoon at the Hospital. He applied yellow oxide of mercury ointment to the eyes with a bandage at night, as he considered smearing ointment merely on the eyelids was almost useless, because grease ran off their moist surfaces. (3) "Lupus vulgaris" in a condition like scrofuloderma. (4) A woman suffering from xeroderma of palms and ichthyosis of legs, improving in health and condition of skin under thyroid extract.

Replying Dr. EDDOWES said too many cases of alopecia occurred with leucoderma for the association to be merely accidental. He looked upon alopecia as a condition produced by several causes, and not as a separate, single disease. He had seen leucoderma recover. He now had greater success in treating alopecia than formerly.

SHEFFIELD MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD THURSDAY, FEBRUARY 1ST, 1900.

The President, Dr. BURGESS, in the Chair.

Dr. BURGESS showed the following cases: (1) A boy with pseudo-hypertrophic paralysis; (2) a woman with argyria; (3) a case of cerebellar ataxia of over a year's duration. There was no optic neuritis, headache, vomiting, and no evidence of syphilis or tuberculosis.

Dr. ARTHUR HALL showed a severe case of tertiary syphilitic ulceration affecting the left orbital and nasal region. The man had acquired syphilis whilst in the army, and had only received six weeks' treatment after the primary infection.

Dr. SINCLAIR WHITE exhibited the following cases: (a) A man, aged 54 years, on whom he had performed supra-pubic prostatectomy for marked enlargement of the middle lobe of the prostate with vesical calculi.

The bladder, which had been in a state of atony for several years, had recovered its tone, and the patient was greatly benefited by the operation. (b) Four cases of resection of the large intestine for cancer. In one case the disease involved the cæcum, and in the other three it was situated in the sigmoid. One of the latter was suffering from acute intestinal obstruction, and resection was preceded by making a temporary artificial anus above the growth. In all four cases a Murphy button was employed, and all made a good recovery. One patient was only twenty-nine years of age. (c) A myomatous uterus removed abdominally with vaginal drainage. The patient made a good recovery, notwithstanding a hernia of the small intestine through the abdominal wound, which was relieved on the third day.

CASES ILLUSTRATING CONSERVATIVE SURGERY OF BONE.

MR. ARTHUR CONNELL showed the following cases:—

Case 1. Lad, æt. 18 had his left hand caught in hay-chopper, the proximal phalanges of the four fingers being divided from dorsal surface, the fingers hanging by flexor tendons and tissues of palmar surface. The phalanges were drilled and brought together with silk-worm gut sutures. Wounds quite healed on eighth day. Patient had good grasp, unimpaired extension, flexion limited. *Case 2.* Patient, æt. 32, compound comminuted fracture of upper fourth of left tibia involving knee-joint. Loose pieces of bone removed, large wedge-shaped part carrying internal tuberosity wired to shaft. Three subsequent operations for small fragments of bone. Perfect movement of joint. Left limb somewhat bowed owing to dropping of internal tuberosity. Patient resumed work one year after accident. *Case 3.* Patient, æt. 23, comminuted fracture of left clavicle, owing to severe fall on shoulder. Attempts at reduction being futile, two silver wire bracelets were passed round fragments, ends of wire bent down on to bone and interlocked, and the periosteum united over these. Wound dressed on eighth day and stitches removed. Result gratifying, position good. Limb unchanged, all movements at shoulder normal.

Prof. MYERS WARD demonstrated the most modern and approved forms of the kymograph, artificial respiration apparatus, volumetric apparatus and other physiological accessories.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, February 9th, 1900.

ARSENIC IN THE ORGANISM.

At the last meeting of the Academy of Medicine, M. Gauthier referred to what he had said at a previous meeting as to the presence of arsenic in the thyroid gland, and that that substance existed equally in appreciable quantity in the skin, the hair, the nails, &c.; traces also were found in the mammary gland, the milk and the bones. On the other hand, it was never found in the liver, spleen, stomach, intestine, pancreas, nor in the blood. Neither did the excretions contain arsenic, consequently it was only by the skin and its appendages that the product was eliminated. That elimination had for result when it had attained certain proportions as after arsenical treatment, for instance, a considerable growth of the hair. It was through certain aliments, notably cabbage, potatoes, turnips, &c., that arsenic was introduced into the organism. Although very appreciable in some organs, the total quantity of arsenic existing in the normal state was very small; it corresponded to 1-200th million of the weight of the body.

M. Lancereaux confirming the statement of his colleague relative to the growth of the hair under the influence of arsenical preparations, said that in a young

woman submitted for over a year to arsenical treatment which determined symmetric paralysis of both legs, he had seen those limbs covered with long black hair which persisted for eighteen months after the suppression of the treatment.

TETANUS.

M. Petit related two cases of subacute traumatic tetanus which were cured by injections of antitetanic toxin, and by the employment of chloral in large doses. The first was that of a man, æt. 26, a butcher, who cut the thumb of the right hand in handling meat. A week afterwards he was seized with pain and contracture at the extremity of right arm, then trismus, opisthotonos, and contractures of the limbs and the thoracic muscles. The patient was treated each day by an injection of the antitetanic serum, and absorbed from three to five drachms of chloral. At the end of three weeks he had completely recovered. The second case was that of a man who got a wound on the head in removing some planks; it was only three weeks afterwards that the symptoms of tetanus showed themselves. His treatment was similar to the preceding, and at the end of four weeks he left the hospital.

M. Vaquez said that some time ago he had treated a young man who showed slight symptoms of tetanus, trismus and stiffness of the neck. Believing that the affection was benign, he injected but small doses of the serum. But five days afterwards the patient, without any warning was seized with violent convulsive attacks, and in twenty-four hours he was dead. The speaker thought that that fatal termination might have been avoided if a larger quantity of serum had been injected.

RESECTION OF THREE YARDS AND A HALF OF THE INTESTINE.

M. Montprofit said that he was called to a man, who had an inguinal hernia of the size of an adult head, which continued to progress, and could neither be maintained nor reduced.

Having resolved to practice the radical cure of this enormous hernia, he made the first incisions, and when the intestine was brought to view it was found to be in such an entangled and mixed up condition that he decided to remove the whole mass. The two divided ends of the intestine were then brought together and sutured without difficulty. The man made an excellent recovery, and were it not for some diarrhoea each time he eats meat he would have suffered no inconvenience from the operation. The mass of intestines removed weighed three pounds and a half and comprised a part of the ileum, the cæcum, the ascending colon, and half of the transverse colon. The total length was nearly ten feet.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, February 10th, 1900.

THE TREATMENT OF NEURASTHENIA.

In the *Munch. Med. Wochens.*, Feb. 3, 1900, Dr. Dornblüth, of Rostock, has a paper on this subject. Before commencing treatment he considers it of prime importance to come to a thorough understanding as to the patient's previous condition and ailments as, frequently, these furnish more or less useful indications. A distinction must be made between the acute and chronic stages, but even in the latter an exacerbation of symptoms occa-

sionally comes on that makes the case for the time much like one in an acute stage. In the acute stage the first requirement is rest, and rest in bed is the best. It is surprising how frequently all the symptoms, those connected with the stomach, the melancholy, giddiness, and oppression, are removed by it alone. Such rest may be required for a period varying from eight days to six weeks. In milder cases it is sometimes difficult to command such rest in bed, but its usefulness is incontestable. When absolute rest in bed cannot be procured, the patient should be enjoined to lie down flat as often, and for as long a time as he or she can each day. For mental rest attention should not be given to business. Loneliness, in the acute stage, very useful to the patient. The tendency to grumbling, which the patient thinks he ought to overcome as much as possible gives way soonest of all to bodily rest in the sick room. A return to occupation should only be allowed after proper rest has been had, and the power of resistance has sufficiently returned.

Diet is of great importance; neurasthenics only require a normal diet. The author understands by this, five meals a day with intervals of two-and-a-half to three hours. He allows coffee and tea, and all not over indigestible articles of food, but unconditionally forbids all alcohol, as it always leaves a lassitude behind it and lowers the recuperative powers of the nervous system. In general, rest after a meal is good, but some patients seem to do better with conversation. A great part of the stomach troubles of neurasthenics are due to insufficient evacuation from the bowels, and disappear when a suitable diet has overcome the difficulty.

Hydro-therapeutics come next, and the author thinks that Preissnitz body wrappings, the half bath and cold wet smacking will suffice. As regard the Preissnitz, the linen cloth should be steeped in water the heat of the patient's room, well wrung out and wrapped round the body. The water used should not be warmer than stated even if the patient expresses a wish to have it so. Over the linen cloth come wrappings of dry flannel, secured with safety pins or bandages. The Preissnitz envelope acts as a calmate, and at the same time a stimulant to the stomach and bowels. The half bath is an ordinary bath, only half filled covering the buttock and lower limbs only. The patient sits up and the front and back are well douched by the attendants, the best temperature is 24 to 25 R. (73 F.), and the bath should last four minutes. The bath is best given soon after a light meal, and the patient should rest a quarter of an hour after it. In drying, rubbing should not be made use of, as only a calmate effect is desired.

The fourth part of the general treatment consists in general Faradisation, a weak current being used preferably through the Faradised hand.

An indispensable part of the treatment lies in psychotherapeutics. Only the truth should be stated, and only what one knows. Any departure from this involves the possibility of contradiction and a shock to confidence.

To these general regulations are now added those applicable to the particular case. A majority of neurasthenics suffer from imperfect constitution of the blood. Krewel's sanguinal pills and arsenic are distinctly useful. According to the case quinine or ext. rhœi may be added to the pills. Arsenic the author generally prescribes in the form of the Asiatic pill, acid

arsen. 0.1, pip. nig. 2.0, pulv. sig. 5.0, and mucilage to 90 pills, of which one is taken three times a day at meal time. After 8 to 10 days 5 to 6 pills may be taken; this may be continued for about 3 weeks, when the 3 pills daily should be reverted to. It is occasionally useful to give large quantities.

In the chronic cases education to labour is of vast importance, especially in those of traumatic neuralsthenia after recovery from the original inquiry, when compensation has been granted and there is a disposition to pass a sort of invalid existence.

ICHTHYOL VASOGEN IN JOINT AFFECTION.

Prof. Edleszen, of Hamburg, has an article on this drug in a recent number of the *Therap. Monats.* (1/1900). The Professor began using ichthyol soon after its first introduction and with good effect. When the vasogen preparation came to hand, he first of all painted the alcohol-ether solution of ichthyol over the joint, and then rubbed in menthol vasogen. He satisfied himself that ichthyol used in this way acted more perfectly and quickly than by simple painting. Since the introduction of the 10 per cent. ichthyol vasogen he has left off the complicated process and has simply used the ichthyol vasogen, and has obtained as good results in a simpler manner. The results were equally favourable in nearly all cases of monarticular rheumatism, and especially in recent cases. In the case of large joints 8 to 10 drops can be rubbed into the skin. In the acute cases the rubbing cannot of course be carried out. In such cases ichthyol should be given internally in the form of pills or capsules, or a return may be made to the older method of painting with the alcohol-ether solution.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, February 9th, 1900.

BACTERIO THERAPY.

DR. IVAN HONL, of Prague, has prepared a history of 100 cases which have been treated by Bukovsky and Professor Janovsky with the protein of bacillus pyocyaneus. The injections of proteins and toxins is no new doctrine, but Professor Janovsky's dressing of indolent ulcers with protein products must be admitted to be a slight deviation from the modern teaching of bacteriologist. His argument is that the bacterial force of an ulcer is varied in character, in it are often found pathogenic, as well as saprophytic micro-organisms. Our object in healing the wound is to free it as much as possible these retarding agents, which so rapidly multiply in spite of antiseptic dressings, such as carbolic, &c. Experiments with the latter and protein dressings are compared to show how ineffectual carbolic is in this respect when compared with protein. Extracts from other micro-organisms, such as staphylococci and streptococci, were proved to act in the same way, the pyocyaneus being more persistent, even refractory, so diphtheria was selected as the most suitable. Any of them are equally potent in the healing of indolent or refractory ulcers.

The protein of the pyocyaneus is obtained in quantity by growing cultures on fluid media, which form a greenish or greenish-yellow pellicle on the surface. From experiments, a suitable age of this culture is found more potent, from which the protein is prepared and

diluted according to Buchner's method. After this fractional sterilisation a dark green, alkaline, cloudy extract is the result. The action of this fluid on healthy animals and man is nil.

The proteine being now ready for use the patient is advised to remain in bed, occasionally putting the extremity affected with the ulcer in lukewarm water. After this the protein lotion is applied twice a day on "hydrophile gaze," which is again covered with a layer of wadding, and finally fastened with a bandage. Of the 100 cases successfully treated only one has been observed to go wrong, i.e., become swollen through a large accumulation of leucocytes. Its salutary action is indisputable. Many false notions are entertained concerning the toxic effect, but it is important to notice that the solution ought to have no bad effects on the organism to obtain sufficient stimulating vital curative force. Another proof of its potency can be demonstrated in the test tube by placing a small portion of this extract in one growing pyocyanus, which instantly checks further progress. The same enzyme action is observed in the lower animals, even proving to be a bactericide for anthrax when injected.

The local application produces no pain, no reddening or subjective symptoms, while the surrounding skin is perfectly healthy. No medicines were given during the treatment, and all the patients expressed themselves as well and comfortable.

Within 24 hours the ulcer will show evident signs of improvement; if a pseudo-membrane be present before the commencement of the enzyme application it will have quite disappeared before the 24 hours. The first dressing and bandaging will be drenched with the discharging secretion which will rapidly disappear in the second or third. The duration of healing is various according to the complications, but in every case it is far shorter than by any other means. Janovsky expresses satisfaction with the results and is sanguine of the future for the protein treatment.

PAUCITY OF MEDICAL STUDENTS.

In recent years the medical profession has not been so much in demand as formerly, and the decrease seems more marked through Austria this year. In Vienna 218 entered for the profession at Prague, 35 Deutsch-speaking and 37 Czechs; Graz, 39; Innsbruck, 24; Lemberg, 13; Cracow, 11; making the small total for Austria of 377.

SUSPICION OF PLAGUE AT CRACOW.

A considerable amount of excitement existed at Cracow last week from the sudden death of the assistant in the Bacteriological Institute under the direction of Prof. Bujwid. Kostanecki, who was considered an able assistant in the infectious laboratory, took suddenly ill, and died on the fourth day with all the symptoms of plague, according to those who attended him, but where the pest came from was a puzzle. Accordingly a post-mortem examination, with microscopic and animal tests, was performed, but the result was a tranquillising report that death was due to "streptococci pneumoniae."

The Operating Theatres.

GUY'S HOSPITAL.

ABSCESS OF THE BRAIN.—MR. ARBUTHNOT LANE operated on a man, *æt.* 33, who had suffered for a week with headache and occasional attacks of vomiting; the temperature was high, and the pulse and respiration

rapid. The headache was most marked on the left side of the head, and there was a good deal of pain and tenderness about the mastoid process on the same side. The membrana tympani was perforated, and there was some foul discharge. He was perfectly intelligent and answered questions correctly and promptly. After a thick, dense mastoid has been removed, the antrum and the petrous bone were found to be much enlarged, and filled with foul-smelling granulation tissue; this was all thoroughly cleared out. The dura mater was stripped both from the upper and posterior aspects of the petrous bone, and there was no evidence of any extra-dural suppuration whatever. On the following day the patient's temperature was normal and he had lost his headache, he was still inclined, however, to be sick. Two days after his headache returned, his temperature rose abruptly and his pulse and respiration again became rapid. The dura mater of the middle fossa which had been freely exposed at the previous operation was now divided, when the brain bulged into the aperture so made; a pair of dressing forceps were passed into the temporo-sphenoidal lobe, when a gush of foul pus took place and about two drachms escaped. The alar cavity was thoroughly washed out and a drainage tube inserted. No optic neuritis was present throughout. Mr. Lane said that the case presented a peculiarity in that, except for the continuance of the vomiting which was trivial after the first operation, there was practically little or no clinical evidence of the presence of a cerebral abscess.

ROYAL FREE HOSPITAL.

NEPHRECTOMY FOR TUBERCULOUS KIDNEY.—MR. BATTLE operated on a woman, *æt.* 20, who had been suffering from pain in the region of the left kidney for a period of from five to six months. The pain had not been that usually associated with the presence of calculus, for it had not been paroxysmal in character. There had been some increased frequency of micturition. The urine had shown a yellowish deposit. There had been no bleeding. During the last month or so the pain had been more severe and almost constant; she had lost flesh, and suffered from night sweats and had been feverish. On examination, the patient was a thin girl with slight hectic flush and somewhat rapid pulse. In the left side of the abdomen occupying the left kidney region, was a large swelling which passed back under the ribs, and moved very little on deep inspiration; it was very tender, and fluctuated in one part. The urine was acid, but contained a deposit of pus. She had the signs of hectic fever but careful examination showed no evidence of tubercle in other parts of the body. The right kidney was enlarged and could be felt, but it was not tender nor in any way changed in its normal outline. The diagnosis was made of tuberculous disease of the left kidney, and as no evidence of tubercle could be found elsewhere it was considered that her hectic was dependent upon the presence of suppuration in the left kidney. The right kidney was regarded as hypertrophied in order to supply the place of its diseased fellow. Everything was apparently favourable for the removal of the tuberculous organ, and it was thought desirable to do the operation of nephrectomy rather than that of nephrotomy with subsequent drainage, because although the former was the more severe operation the patient would get rid of the source

of her trouble, whereas if the latter operation was performed there would be continued drain on the system, which she was ill prepared to sustain. Had nephrotomy been done it would probably have necessitated nephrectomy at a later stage, when she would be still further weakened by constant discharge. Chloroform was administered for the operation, and the kidney removed through a lumbar incision. The capsule of the organ was opened, and the kidney shelled out from it. This was easy in the lower part, but in the upper part it was extremely difficult, for not only had a large abscess developed above and posteriorly, but the adhesions of the kidney to the capsule, and the capsule to the diaphragm were extremely dense, and their greatest resistance was at a point difficult to reach, and most cramping to the operator. After the kidney had been drawn into the wound, the ureter and vessels were ligatured separately, a drainage tube introduced, and the wound closed, separate stitches being used for the muscular layers and skin. The ureter where cut showed some change in its lining membrane, suggestive of the possibility of tubercle, but the condition of the patient after such a severe operation did not permit of further exploration. Section of the kidney showed that besides the large abscess which communicated with the upper and posterior part of the organ there were other centres of disease, most of which had undergone changes into abscess cavities. One of fairly large size occupied the position in front of the kidney, and was evidently the one which gave rise to the sensation of fluctuation when the organ was examined before operation. Mr. Battle said that his opinion when he first saw the patient was unfavourable to the performance of nephrectomy. The patient had a very hectic look, was emaciated, and had a rapid weak pulse, there was a little cough suggesting the probability of lung disease, the right kidney could be felt considerably enlarged and this might have been due to disease on that side also; when, however, examination of the lungs showed nothing more than a little crepitation at the left base when the right kidney did not increase in size, whilst the signs of suppuration about the left kidney increased, he took a more favourable view; he considered that the prognosis in cases of tubercle of the kidney was far better than was generally thought if operation was performed early, and instanced the case of a patient on whom he had performed nephrectomy for this condition some twelve years ago who was still alive and healthy.

GREAT NORTHERN HOSPITAL.

WIRING FRACTURED PATELLA.—Mr. PEYTON BEALE operated on a woman, *et. about 30*, who had fractured her patella three weeks previously. He performed the open operation, and on exposing the patella found that the torn ends of the ligamentum patellæ were firmly adherent to the fractured bone surfaces. The fractured edges of the bone having been cleaned by the removal of the internal ends of the ligament, together with much tough almost cartilaginous tissue, two wires were inserted in the usual manner and the ends tightened up. The aponeuroses on each side were freely divided so as to relieve the slight tension which was present, the cavity of the joint was thoroughly irrigated and the wound closed. Mr. Beale said that in his experience, in about four cases out of every five he found the torn ends of the ligamentum patellæ firmly adherent to the

bone surfaces; unless these were dissected off bony union was of course impossible. It might be asked why should not the operation be done before this adhesion had taken place; if the case could be operated on within one hour of the occurrence of the fracture, it might be possible to ensure bony surfaces being placed in accurate apposition by external manipulation, and then a subcutaneous operation, such as that devised by Mr. Arthur Barker might be performed; but he could not see that there was really any less danger to the patient in this procedure than there was in operating by the open method. In by far the majority of cases of fractured patella the surgeon did not see the patient until some hours after the injury. In most cases the joint was then found partly or wholly distended with blood. If the case was watched carefully it would be found that there was a rise in temperature local and general, which persisted more or less until after the effused blood had clotted, or in some cases until its complete absorption. This might take place in a few days or it might take several weeks. He believed the rise in temperature was due to the absorption of fibrin ferment, probably by the lymphatics, and such a rise in temperature was usual after the rapid effusion of blood into other cavities of the body; he considered that there was grave risk to the patient in operating for fractured patella during this period, as the joint synovial membrane was, under these circumstances, not unable to resist infection should even a few septic organisms be present. He further remarked that it had been stated that bony union never took place even after the most accurate wiring, but against this he could say that in a case under his care some years ago he had occasion to wire a patella which had become fractured two years after a former wiring performed by him. The fracture at the second operation was found to be about $\frac{1}{4}$ of an inch above the site of the previous one, the wire had, of course, been broken, but the line of bone union was complete, and he excised it and had it at present in his possession.

THE SERUM TREATMENT IN SHEFFIELD.—

In a recent article in the "Quarterly Medical Journal for Yorkshire," Dr. Alexander Anderson gives his personal experience of the results of the treatment of diphtheria. In all 258 cases were admitted to the City Hospital during the year 1899, and of these 41 died, equal to a mortality of 15·8 per cent. Owing to the lack of hospital accommodation a comparatively small proportion of the total number of notified cases could find admission, as many as 46 per cent. being admitted on the fifth day or later. This fact amply explains the author's not having obtained an even more pronounced reduction in the mortality, the efficacy of the serum, as is well known, being immensely diminished by any delay in instituting the treatment. Even so, the figures testify eloquently to the value of the method, and Dr. Anderson was able to adduce some very telling details in disproof of the assertion that the reduced mortality was due to the milder type of the disease.

A MAN, who was stated to be Dr. Alexander Forsyth, committed suicide on Friday last at Leyton after fatally shooting a woman with whom he had cohabited.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, FEBRUARY 14 1900.

POSSIBLE WAR COMPLICATIONS.

THE mobility and accurate marksmanship of the enemy are not the only dangers which the soldier at the front has to fear in South Africa. The difficulty of ensuring adequate sanitation in hastily constructed camps, especially when the energy of the men is fully occupied in warding off attacks, exposes our soldiers to the ravages of disease, foremost among which are typhoid and dysentery, which spread but too rapidly when once they have obtained a footing. Apart from water-borne diseases there are others which may conceivably impair the value of a fighting force, in direct proportion to its size. We have not heard of any outbreaks of variola, and it is to be hoped that the precautions taken to ensure efficient vaccination, at any rate in the regular Army and in the Militia, will prove sufficient to ward off any danger from this source, but how far this holds good of the various volunteer corps it is impossible even to guess. There is, however, always present the danger of the importation of plague by troops arriving from India. Several cases of plague have occurred in or near Delagoa Bay, and the possibility of an outbreak among the soldiers in the field is too awful to contemplate. In view of this contingency it is to be hoped that the Government will take all possible precautions, especially in respect of the means of supplying, if necessary, adequate quantities of the serum. What the value of the serum treatment would be under the peculiarly trying circumstances of a campaign experience alone can decide, but as it is practically the only means, other than rigorous sanitation, which is available for the purpose of nipping a threatened epidemic, its employment would be clearly indicated. The part played by vermin in the dissemination of the plague is now universally recognised, and port

sanitary authorities ought to be specially on their guard against the escape of rats from ships bringing troops or merchandise from parts of the world where the plague exists. In an article on the subject which appeared in a recent number of the *New York Medical Record* we are reminded that the belief that rats were an important factor in spreading the plague was firmly held by the ancient Greeks. Sambon relates that in Asia Minor, at the very door of the plague, they worshiped Appollo "εμυροφ," "that is to say, Apollo the rat, whose arrows spread the plague. and at the same time as the destroyer of rats." This awful divinity was represented on monuments as treading on a rat. In Roman times, when Æsculapius replaced the more ancient god of medicine, we again find the same fact recalled on a coin of Lucius Verus, struck at Pergamum. It represents Æsculapius with a rat at his feet, and a small naked figure standing by with arms outstretched. It is, however, not absolutely proven that the plague is disseminated by rats, although the evidence in support of the theory is remarkably strong—so strong indeed that the destruction of these vermin in infected regions and ships is a course that should, in all instances, be pursued. With regard to the plague in Portuguese South Africa, says our contemporary, there can be no doubt but that it constitutes a grave menace to both the armies in the field. In the first instance it will find an eminently congenial soil amid the filth of the Portuguese towns, and in the second place the transportation of provisions from Lorenzo Marques to the Transvaal will afford favourable facilities for its introduction to that country. In order to prevent so frightful a catastrophe, pressure should be brought to bear upon the Portuguese authorities to induce them to exercise the strictest supervision both over cargoes coming in by sea and over the food stuffs sent inland.

THE ROYAL COMMISSION AND THE LONDON WATER SUPPLY.

THE Final Report of the Royal Commission on the London Water Supply is a document of first importance. Its main conclusions are likely to postpone any real settlement of the question dealt with to an indefinite period, while they bring once again into striking relief the general chaos of administration that characterises the greatest and richest city in the world. Curious as it may seem, there is little doubt that when a small village or a provincial town, such as Manchester, could settle the vital matter of its water supply out of hand, London, with all her unbounded wealth and energies, nevertheless lies helpless at the mercy of competing water corporations and of conflicting local authorities. As most of our readers know, London is divided into an inner administrative county, a far larger area known as "Water London," and a still wider district included within the Metropolitan and City police jurisdiction. Six counties enter into the greater combination, namely: Middlesex, Kent, Hertfordshire, Surrey, Essex, and London itself, as

well as several boroughs and some fifty-six urban and rural district councils. In such a complex tangle of affairs it is hardly a matter of wonder that there should be a variety of opinion as to how an efficient administration may be best secured. The outlying counties have protested with one voice against their water supplies being acquired by purchase by the London County Council. Their chief ground appears to be that only a small proportion of their own inhabitants fall within the jurisdiction of the London Council. The Commissioners regard the present conditions of the water-supply as so intricate that a scheme of physical severance and partition would be impracticable. Their chief recommendation is that the Metropolitan water companies' undertakings should be purchased and placed under the control of a "Water Board." They regarded purchase by the London County Council as inadvisable. This latter view is based upon the assumption that such a step on the part of the Council would necessarily involve a division of the works of supply, which appears to them impracticable. That the results of Lord Llandaff's Commission will prove disappointing to those who anticipated a speedy solution of the problem must be obvious. Some day a comprehensive scheme worthy of Londoners' acceptance will doubtless be brought forward and adopted, but meanwhile the day of fruition has been indefinitely postponed. It has been found possible to give to such cities as Birmingham, Manchester, and Edinburgh good supplies of pure water from more or less distant mountain catchments. What is possible in the provinces can surely not be altogether impossible in London, in spite of the absence of any common municipal vitality in that huge conglomeration of local authorities. The City of London, the nucleus around which greater London has gradually grown, has alone maintained a strenuous tradition of united citizenship, with the natural result that hitherto its finances and organisation have proved unassailable. It is true that the London County Council has introduced some sort of municipal element into the life of greater London, a laudable spirit that may or may not be further advanced by the forthcoming redistribution of districts under Mr. Balfour's Act. Anyway, from an early period of their existence, the London County Council took up the water question, and it is to be hoped their well-known energy and pertinacity will not be staved of by such unsatisfying conclusions as those contained in the Report of the Royal Commission. For years past the annual recurrence of a water famine in the East End of the Metropolis has forced an object lesson upon all citizens as to the good faith and generosity of water companies, who owe their position to concessions granted at the cost of the community. Add to that the fact that Londoners are, for the most part, supplied with water that has been polluted by sewage, and the need for a thorough and radical change in the source of supply must be self-evident. Of the vast amount of disease of unknown origin met with every year in the Metropolis, it seems not unreason-

able to assume that a fair proportion may be ascribed to the drinking of specifically polluted water. In any case, we have no hesitation in asserting that to supply to a community water that has been contaminated by sewage is to run counter, not only to common sense, but also to the established canons of preventive medicine. Yet the Water Commission, if we read between the lines of the Report, asks us to continue the state of things that makes such a polluted supply possible. As we have often pointed out, the water companies have a vast influence, which is constantly excited in their own favour and to the detriment of the people in Parliament as well as in other directions. The chief hope for the future lies in a strong House of Commons that will not allow capitalists to stand in the way of the interests of the community. It is to be hoped that the London County Council, having laid their hand to the plough, will not be deterred by any amount of opposition from their set purpose of securing to greater London a municipal supply of pure water, if need be, from the Welsh hills. Some day, as we have already said, that consummation must be brought about, and the longer it is delayed the greater the damage, direct and indirect, to the pockets and the health of those who are by virtue of position the unwilling drinkers of water that has been subject to dangerous and revolting pollution.

THE ARMY MEDICAL DEPARTMENT AND THE WAR.

If the progress of the war in South Africa so far has proved anything, it has shown, contrary to expectation, that the Army possesses a most efficient medical service. From all sides testimony to this effect has been given. Lord Methuen has even said that he was glad that he had been wounded, inasmuch as the opportunity was thus afforded him of learning how complete and perfect were the arrangements for dealing with his wounded men. All this is, without doubt, very satisfactory; it has silenced the gloomy wailing of the pessimists who prognosticated that the medical service of the Army would show lamentable inefficiency during the course of the war. Moreover, there were not wanting some who affirmed that the sick and wounded troops would be exposed to hardships scarcely less in severity than those which befell our gallant soldiers in the Crimean war. Despite, however, all these prognostications of evil, the reverse has proved to be the case, that is to say, both officers and men from the highest to the lowest in the South African Field Force, have never lost an opportunity of bestowing warm praise and admiration upon the work done by the Medical Department. As showing on the other hand, how closely matters affecting our wounded soldiers are being scrutinised by the public, it may be pointed out that questions were asked in the Houses of Parliament last week respecting some statements as to defects in the military hospitals in Cape Colony and Natal. But the Ministerial reply was well calculated to allay all alarm and anxiety upon this score. The Government were able to produce

telegrams from the Commander-in-Chief in South Africa as well as from Sir R. Buller, in both of which the statements were described as false and ridiculous, and the assurance of Mr. Treves was also given to the effect that there was no possible ground of complaint, and that he could not suggest any improvement upon the arrangements which had been made for the care of the wounded. It is with considerable satisfaction that we are able to make these remarks, for it must not be lost sight of that no thanks are due to the military authorities for the efficiency which the medical department has displayed. Let it be borne in mind in this connection how many times the officers of the Royal Army Medical Corps have been snubbed in their efforts to add to the efficiency of their department. The War Office have repeatedly in the past done their utmost to check enterprise in this direction, but despite the petty jealousies, want of encouragement, and obstructive policy opposed to them, the Medical Department have made the best of their limited opportunities, and it is only true to say that the one bright feature of the war so far has been the care and attention which have been bestowed upon the wounded, and the wonderful perfection which has been shown in the organisation of the medical department generally. To whom, it may be asked, can these results be attributed if not to our *confreres* in the Service? No matter what the results of the war may be, it will have proved one thing, namely, that the Army possesses a Medical department of which the nation has abundant reason to be proud. Indeed, as a matter of fact, both the War Office and the Government owe a debt of gratitude to the officers of the Royal Army Medical Corps for the successful work which they have been able to accomplish, for in truth matters might have been very different had the chronic system of ennobling been taken seriously to heart by the latter. In short, then, we rejoice that our *confreres* in the service have proved themselves equal to the task imposed upon them, and we also trust that after the war a new *regime* will be inaugurated as between the military authorities and the Army Medical Department. It is difficult to see how, for example, Sir Redvers Buller could, after his recent experience of the treatment of the wounded at the battle of Colenso, ever forget his indebtedness to the medical officers of his command. No one probably knows better than Sir Redvers Buller himself the dire consequences which would have ensued had a failure occurred in the arrangements for the succour of the wounded.

Notes on Current Topics.

Dr. Neale and the Profession.

WE publish elsewhere an influentially-signed appeal to the profession embodying a suggestion which cannot but meet with general approval. We refer to the proposal to constitute a fund for the purpose of presenting Dr. Neale, the author of the well-known Digest bearing his name, with a testimonial of some

sort in order to convey to him in tangible form the appreciation of the profession of the public spirit and perseverance which he has displayed since upwards of forty years in compiling the work in question. Members of the profession, and they must be numerous, who are familiar with the "Digest" do not need to be reminded of the immense amount of time and labour which the routine work of posting up the references has entailed. It is not merely a simple and comprehensive guide to the title and tenour of the various articles and contributions which have appeared for more than forty years past in British medical journals, but, viewed as an index, it affords at a glance a working idea of the various methods of treating a given malady, &c. Without such a guide as this, medical literature is a chaotic accumulation of facts, suggestions, and results which virtually defies analysis. The "Digest" is as useful to the busy practitioner as it is indispensable to the author in search of references, and it is to be hoped that arrangements will be made to continue its publication when the time comes for its venerable author to relinquish the task. We understand that something of the kind is contemplated, but before accepting the undertaking it is only becoming that those who have availed themselves of Dr. Neale's labour of love—for it has been such, no question of profit having ever been considered—should seize this opportunity of conveying to Dr. Neale an assurance of their appreciation, coupled with an object which will remain as evidence of grateful recognition of his life's work.

Measles a "Trivial Complaint."

THE fallacy that measles is a malady of little significance still lingers in the popular mind, in spite of the growing intelligence of the community upon such matters. A striking illustration of the deep-rooted nature of that conviction will be found in the current issue of the *North American Review*. In the course of an historical article, Professor Bryce says that measles, when it occurs in civilised countries is, a "harmless childish malady," but when imported among savage nations becomes a deadly plague. The passages occurs as an incidental simile that would not be surprising from the pen of a busy lay journalist who has not time to probe the medical beliefs of the multitude. It is, otherwise, however, with a man of the marvellously wide culture and universal knowledge that characterises Professor Bryce, whom we cannot believe to be unacquainted with the chief features of the Registrar-General's returns for the United Kingdom. As a matter of fact, if we take the seven principal zymotic diseases we find that for the two yearly periods ending 1890—1895 measles comes second highest on the list, which in each case is headed by diarrhoea. Has the learned professor never heard the question mooted as to whether measles should not be made a notifiable disease? Some years ago the point was ably discussed in an article under the heading "Murder by Measles," which appeared in the *Nineteenth Century*, a journal that presumably falls within the scope of professional reading. Apparently it is only when grown-up

savages are killed off in thousands that the deadly nature of measles is recognised; civilised babies do not weigh so much in the intellectual balance.

An Interrupted Pilgrimage.

BETWEEN three and four hundred pilgrims left Marseilles last week on their road to Rome, and all went well until they reached the Italian frontier where they were met by a staff of doctors who had instructions to vaccinate them all, and, failing compliance, the military authorities had orders to refuse admission. It seems that a number of cases of grave variola have made their appearance from time to time in northern Italy, which have been traced to travellers from Marseilles, hence this somewhat drastic measure which resulted in a large number of the pilgrims refusing to submit to the "indignity," and retracing their steps. The example is one which might advantageously be followed nearer home for Government would be perfectly justified in refusing admission to travellers who, failing evidence of recent successful vaccination, refused to submit thereto.

Whisky Drinking.

IN an address recently delivered before a provincial medical society, Dr. Goodhart called attention to the extent to which whisky, as a beverage, had supplanted beer during the last half a century or so, and he did not hesitate to render the medical profession as a body responsible in part for a change which he views as pernicious. Most practitioners of experience will concur in the general truth of Dr. Goodhart's remarks on the subject, though they may be reluctant to accept the responsibility which he would place on their shoulders. The advantage of drinking what may be called "natural" beverages is that excess is immediately followed by more or less acute gastric and physical discomfort which tend to remind the delinquent that he is exceeding the mark. Distilled alcohol, on the other hand, is more insidious in its effects, and produces pathological changes which seldom follow the habitual ingestion of the milder drinks even in comparative excess. During the last two or three decades a great and welcome change has come over the scene in regard to the attitude of medical men towards alcoholic indulgence of any kind, and in view of the position of trust which medical men hold towards the public it behoves them to think twice before giving advice which may be construed into approval or recognition of the necessity for the routine use of alcoholic beverages.

Damages Against a Locum Tenens

AN action which was on the list for trial at the Burnley County Court last week, but which fell through in the absence of the plaintiff, throws a side light on the risks which practitioners run when they hand over their practices to the tender mercies of inattentive substitutes. The claim was for salary due to the plaintiff, Dr. J. F. Wilson, by Dr. F. E. Crossley, whose practice he had had charge of, and who made a counter claim for £50. On the counter claim being tried it was stated that Dr. Wilson

had grossly neglected his duties as locum tenens, and in a specific instance it was stated that he had omitted to visit an elderly patient whom he had been directed to see daily, and it was mentioned that Dr. Wilson had ultimately given a certificate of death, not having seen the patient during life. In reply to a remark by the judge it was stated that the facts concerning the certificate would probably be brought before the General Medical Council. The judge commented roundly on Dr. Wilson's conduct, and gave a verdict against him for £35. The case shows the extreme desirability of ascertaining the trustworthiness of the substitute one proposes to leave in charge, but unfortunately this is often a matter of great difficulty.

Stamp Collectors and Tuberculosis.

A SURGEON in the French army has just discovered that stamp collectors may be the means of disseminating tuberculosis by means of the stamps. He had in his employ a man suffering from advanced pulmonary tuberculosis, in whose sputa the tubercle bacilli swarmed. This man was a great stamp collector, and occupied his spare time in fixing the stamps in albums or on sheets of gummed paper for sale, moistening the stamps for the purpose with his tongue. As soon as it was discovered that the man was using his saliva to moisten the stamps, he was admonished not to continue the practice, and meanwhile 300 of them were taken and placed in sterilised water. Some of this water was used for the purpose of inoculation experiments. Eight guinea pigs were thus inoculated, and each of them died with characteristic tuberculous lesions. The risks which these experiments indicate of tuberculosis being disseminated by stamps should induce care among those handling the latter, and children especially should be warned against placing any stamps near their mouths in order to moisten them. But the tubercle bacilli are not the only pathogenic organisms which could be disseminated. Mention in this connection may be made of the diphtheria bacillus, also that of pneumonia, syphilis and others. Perhaps, however, to make quite certain of newly-bought foreign stamps being free from pathogenic infection it would be advisable to disinfect them in a 5 per cent. solution of carbolic acid, before adding them to collections.

Celery and Typhoid.

A FEW years ago a large number of cases of typhoid fever were traced to the popular water-cress, and there was a great decline in the use of this vegetable in consequence. A somewhat similar report has now been promulgated in regard to celery. Such risks, of course, must always obtain more or less, in the case of all vegetables which are taken from artificially fertilised gardens and eaten in an uncooked state. Inadvertently typhoid infected material might be used to stimulate the growth of celery, and it is not difficult to comprehend how an epidemic of the disease might thus be caused. The possibility, at all events, of such a contingency is

worth noting, especially when seeking to ascertain the cause of an outbreak of the disease which may seem to be inexplicable.

Hydrophobia in Athens.

It is interesting to peruse the statistics of the Pasteur Institute in Athens, where from August, 1894, to the end of 1897 no fewer than 997 persons underwent the anti-rabic treatment. Among the whole number so treated there were only two deaths or a percentage of 0.25. In five persons, however, the disease developed within fifteen days after the last inoculation. Among those not treated at the Institute there were forty persons who died of hydrophobia in twenty-seven of these the incubation period varied from twenty to one hundred and twenty days; in two, from five to six months, in one, from six to seven months, and in one beyond a year. These figures undeniably show a preponderance of results in favour of Pasteur's method. Of course it might be argued that many of the cases treated by this method would probably never develop hydrophobia in any case, but we do not regard such a contention as a reason for failure to submit to the only method of the prevention of the disease which science has been able to elaborate.

Medical Men and Tobacco.

At a recent meeting, at Manchester, of the British Anti-Tobacco League, regret was expressed at the difficulty experienced in getting the medical profession to take up the question. The fact is that although medical men fully recognise the evil effects of excessive indulgence in the weed, they are not sufficiently convinced of the mischief attending its moderate use to take sides; moreover, a very large proportion of medical men smoke themselves, so that they could not very well support a movement which has for object the abolition of the practice. If one may judge from what one sees at medical dinners the proportion of non-smokers among medical practitioners must be very small indeed, and many, among those who abstain from the fragrant weed, do so, not in virtue of any moral principle, but simply because nature has made them unduly sensitive, and intolerant of its effects.

Chloroform Administration.

It is encouraging to find that the principle of regulating the administration of chloroform is gradually making its way. Another important point is to "go easy" at first, in opposition to the vicious plan of giving initial massive doses as advocated and practised in Scotland. Practitioners should lay to heart the remark with which Dr. James Edmunds, the anæsthetist, concludes a letter on the subject addressed to a contemporary. He says: "Now that I have got used to the improved Krohne inhaler, and realise the true significance of the deaths, I should think it a crime to go back to the towel or Skinner's mask." This is an opinion which we have frequently felt called upon to express when recording additions to the interminable list of fatalities under chloro-

form, the vast majority of which appear, as far as one can judge, to be due to simple mal-administration.

More Malarial Observations from Koch.

A SECOND report on his expedition to the Far East has been published by Professor Koch. Although no facts of startling novelty are contained therein, it nevertheless presents various points of interest. In Dutch India his Java headquarters were in Batavia and Ambarawa. In the former place malaria has diminished during the last fifteen years, more than 50 per cent., probably on account of the free distribution of vast quantities of quinine to the inhabitants. The spare time at that place was devoted to testing the communicability of the disease to orang-outangs by injected blood taken from patients suffering with tertian and tropical ague. None of the animals took the infection, but it must not be supposed that other lower animals cannot harbour the specific parasites in their blood. Meanwhile it seems probable that man is the only bearer of the parasites, a likelihood that cannot fail to have a direct bearing upon prevention. The other district, Ambarawa, is swampy, but, contrary to expectation, very few cases were found among adults. Koch concludes that in order to find out whether a district is malarial or not, the children should be first examined. In a hill district, Tosari, which was said to be free of mosquitoes and of malaria, the children were found to be exempt from the disease. In that fortunate spot there is no cultivation of rice, a fact that is in accordance with Professor Koch's observation that the growing of rice and the presence of mosquitoes go hand in hand. The agency of these insects forms one of the most fascinating chapters of modern medical science, and these latest researches appear to confirm the Berlin Professor's dictum to the effect that where there are no mosquitoes there is no malaria.

Poisoning by Coal Gas.

CONSIDERING the extreme toxicity of coal gas when inhaled it is a matter for surprise that fatalities are not more frequent than they are as the result of leakage. This comparative immunity is probably due to its powerful and characteristic odour, but in spite of this protection two ladies recently succumbed to its effects at Wednesbury. The risk is vastly greater when an inodorous illuminant—such as water gas—is used on a large scale, and in the United States, where it has come largely into use, the frequency of fatal accidents have rendered necessary certain stringent precautions. This is a class of risk which the spread of electricity as an illuminant tends to reduce year by year, but so long as gas is used we shall always have to bemoan a long list of victims, due to its explosive and toxic properties.

THE Professorship of Medicine, or the Practice of Physic in the University of Edinburgh, vacant through the death of Sir Thomas Grainger Stewart, is worth about £1,050 a year. It is in the gift of the Curators of Patronage.

Frozen Meat.

CHEAP food is essential to the rapid growth of a nation. Expansion however, may sometimes be paid for somewhat dearly by reason of unsuspected dangers that lurk in imported food stuffs. From this point of view a few words of caution may not be amiss upon the subject of frozen meat, which has of recent years been brought into the United Kingdom in such vast quantities as simply to revolutionise the conditions of our meat supply. There can be little doubt that cold storage lessens the flavour and nutritive value that is found in fresh meat, but the lessening is probably not sufficiently serious to detract from the value of frozen meat. A more important point is that beef, mutton, poultry, fish, and other animal food that has been frozen, as a rule is thereby rendered less digestible. Another point is that such food, when exposed and thawed is liable to rapid decomposition, and there can be no doubt whatever that a great many cases of ptomaine mischief are due to that fact. Now-a-days the use of frozen meat is universal. Butchers in wealthy neighbourhoods, no matter what their labels, supply imported mutton almost exclusively, and to a less extent imported beef. It is almost impossible to distinguish good Australian mutton, when properly cooked, from that of prime British sheep, while the cost of the colonial product is less by about one-third. In the face of the enormous recent growth of the frozen meat trade it is well to impress upon the mind of the average citizen the desirability of having all meat prepared for table as soon as possible after its arrival from the butcher. Further, that he should have a well ventilated and dust-proof larder.

Syphilis and Dentistry.

It seems to be generally believed that syphilis can be conveyed during the act of shaving in barbers' shops, and the mere possibility of such a terrible contingency occurring strongly emphasises the necessity of enforcing absolute cleanliness in regard to the use of all appliances in these establishments. However, a practitioner has just pointed out that syphilis can be easily transmitted by means of dental instruments, and he refers to several cases, notes of which he publishes in the *Journal of the American Medical Association*, in which syphilitic infection was thus conveyed. But the danger in such cases seems to lie not so much in the infected instruments as in the want of acquaintance among dentists of the lesions common to the disease. For example, any dentist, we presume, called upon to attend a patient's teeth who is suffering from syphilitic manifestations in the mouth, would at once take the greatest precautions in the cleansing of his instruments. Perhaps, indeed, there are some dentists who only use one set of instruments for patients who are known to be syphilitic. Wherever this is done, of course, the best safeguard is provided. But if a dentist is not familiar with the oral appearances of syphilis, how is he to know when special precautions are necessary? It is no doubt quite possible to thoroughly cleanse dental instruments

after use upon a syphilitic patient, and render them sterile and safe for use subsequently upon healthy patients, but what is wanted is the knowledge when such processes of sterilisation are most urgently needed. That there is some justification for drawing attention to this subject is undeniably proved by the cases recorded in the journal above mentioned.

War as a Social Disturbing Element.

IN all probability among the many social disturbances which the war has caused, that which relates to the spending of money will be most severely felt. The public have practically been drained of their spare funds in the interests of the soldiers and sailors on active service. Consequently it is not surprising to hear that hospital charities are already beginning to feel the pinch caused by depleted exchequers. In truth there is every reason for believing that great difficulties are in store for those institutions which depend for their support "on voluntary contributions." The philanthropy of the public is not unlimited; nor are philanthropic persons always mindful of the inexpediency—perhaps injustice—of expending all their charity upon one object, which at the time may happen to be the most popular. Undoubtedly the most pressing problem—excluding the war—during the rest of the year will be how to make financial provision for our hospitals, and the outlook is decidedly gloomy.

Leicester and Vaccination.

THE newly-appointed vaccination officer at Leicester has just furnished his first return and it certainly contains some remarkable figures. We learn, for example, that during 1898 there were 6,164 births in the town, and only 87 successful vaccinations. Again, during the first half of 1899 the births were 3,200, and the successful vaccinations 35, that is to say, that in the course of 18 months the births were 9,364, and the vaccinations only 122. Still more remarkable, however, are the following figures:—During 1898, 1,075 exemption certificates were granted, while during 1899 the number was no more than 113. Possibly, therefore, in the future, Leicester, despite its Board of Guardians, may prove to be a well vaccinated community.

DR. HOWARD KELLY, says the *N.Y. Medical Record*, was bitten on the finger by a rattlesnake recently while lecturing at the Johns Hopkins University. He sucked the wound for a few minutes, and then resumed his lecture, apparently not in the least disconcerted by the accident. The subject of the lecture is not given, and one is reduced to conjecture to explain the presence of this uncongenial reptile in the lecture theatre.

THE Hungarian Government is stated to have promulgated a decree placing ritual circumcision under medical supervision with the object of ensuring that it shall always be performed with due regard to antiseptic precautions.

Welsh County Sanitation.

WALES is generally accredited with holding the most backward sanitary position among the countries of the United Kingdom. Some light was thrown upon the causes of that unenviable sloth in a recent discussion that took place in the Monmouthshire County Council anent the recommendation of the Sanitary Committee that a Medical Officer of Health be appointed for the whole county at a salary of £500, with £100 for travelling expenses. The main objection raised against the proposition was that such an official would not have it in his power to do more than make recommendations which the local authorities would not carry into effect. It was further contended that only one Welsh county, Glamorgan, had a County Medical Officer, a fact that seemed highly satisfactory to the opponents of the proposed appointment. On the other side it was pointed out that certain "plague spots" in Monmouthshire were under the care of a Medical Officer engaged in private practice, and that the work done under such circumstances was perfunctory and "not always unbiassed." Alderman Reiffan maintained it was fully time the Council ceased playing with the sanitation of the county. He followed up that home thrust by ridiculing the idea that a County Medical Officer would be powerless, for his recommendation could be enforced through the Local Government Board. In his opinion they were shrinking not from the additional rate of one-sixth of a penny that would be required, but from the recommendations that the officer must make to them if appointed. The determination not to appoint a County Medical Officer was carried by thirty-three votes to twelve, and Monmouthshire has thus formally maintained her right to remain a laggard in the sanitary race.

The Registrar-Generalship for Ireland.

THIS important position has not yet been filled since the death of Dr. Grimshaw, probably in consequence of the serious illness of the Chief Secretary. As the emoluments of the office amount to a large sum, and, as the position is one of honor and influence, there is much competition for it. When it became vacant the choice of the profession fell at once on Dr. J. W. Moore, President of the Royal College of Physicians, who is known, not only as an able and experienced statistician, but as a skilled sanitarian and a cultured writer. He is, however, too busy with practice to allow him to accept of the appointment. Dr. Atthill, representative of the Dublin College of Physicians in the General Medical Council, whose name appeared in an erroneous list in a daily contemporary, also disclaims the honor. As far as we have been informed, the prominent competitors are:—(1) Mr. Robert E. Matheson, (2) Dr. Ninian Falkiner, (3) Dr. Martley, and (4) Dr. Langford Symes. Mr. Matheson is secretary of the department and assistant-registrar, and, if nothing save long and efficient service in the office were to decide the selection, would certainly obtain the desired position. But there is a strong feeling, especially in the medical profession, that no one

can be competent to compile and reason from the statistics of mortality and disease but an expert in medical affairs, and, preferably, one who is familiar with the detail working of the registration system in Ireland. Dr. Grimshaw, during his period of office, has proved the superiority of the medical claim to all others, and we trust that the Government will not ignore the fact.

Dr. Falkiner is a fellow of the College of Physicians, and recently acted as Secretary of the State Medicine Section of the Royal Academy of Medicine. He is also a diplomate in State Medicine of the University of Dublin, and has had many years' experience of the registration system as registrar to one of the North City Dispensaries.

Dr. Martley is also a Fellow of the College of Physicians, and one of its State Medicine diplomates, and he has shown his capacity for compilation and interpretation of statistics by communications on the etiology of cancer.

Dr. Langford Symes is also a Fellow of the College of Physicians, and was for some years registrar of one of the largest districts in Ireland, when he published an exhaustive report of the statistics of Public Health, and an epitome of "The Laws of Public Health." He is additional examiner in Medical Jurisprudence and Hygiene for the College, and investigated "The Mortality of Children in Ireland," bringing the causes of "Infantile Mortality" before the Royal Academy. Many other candidates are spoken of, but, as we have no official knowledge of their candidature, we are not in position to name them.

The Proposed Midwives' Registration Bill.

THE declining interest in this question has been suddenly revived by the announcement that the promoters of the Bill to make provision for it have been so lucky as to secure an exceptionally good place on the ballot, and have fixed the second reading for the 28th inst. It is probable that the Bill will then be pushed over by the Mines Regulation Bill, which has the place before it on the same day, but we strongly advise the opponents of the Bills not to be lulled into inaction by this fact, as it is quite possible that the last-named measure will be disposed of at an early hour.

Royal Visit to Netley.

PRINCESS CHRISTIAN and her daughter, Princess Victoria of Schleswig-Holstein, paid a private visit to the sick and wounded from the war at Netley Hospital last week, and left a bouquet with certain of the more interesting among the wounded as a gift from Her Majesty. They saw in all some three hundred patients, only one-fourth of whom are confined to their beds. The Queen is expected to pay another visit to the hospital during the present week.

THE office of Serjeant-Surgeon and Assistant Serjeant-Surgeon, at one time held by the late Sir James Paget and the late Sir Prescott Hewitt, have not been filled, and it is surmised that it is the intention of Her Majesty to allow them to lapse.

The offices are ancient and comport an annual retaining fee of £280, originally intended to secure the services of the holder to the king on the field of battle.

IN reply to a question by Sir Walter Foster, Mr. Wyndham stated that 368 officers of the Army Medical Corps were employed in South Africa, 377 at foreign stations, and 111 at home. There were 133 civilian surgeons employed in South Africa, and 28 more were under orders to go. There were 112 retired pay officers employed at home.

A PRELIMINARY meeting of the Dublin Sanitary Commission was held on the 7th inst., and arrangements were made for proceeding with the inquiry at once. Meanwhile, advertisements have been issued inviting all who think that they can contribute useful information to the Commission to send in their names.

DR. CHARLES P. TENANT, of Portnard, in the County Limerick, lost his life last week by taking a draught of carbolic acid by mistake instead of spirits which he had in the same pocket.

WE understand that the Governors of the City of Dublin Hospital, at their meeting on the 1st inst., decided to establish a nursing establishment of their own and dispense with the service of the nursing institute, which has heretofore catered for the requirements of the hospital.

PERSONAL.

DR. W. PASTEUR, F.R.C.P., Lond., has been appointed a Lecturer on Medicine in the Middlesex Hospital Medical School.

DR. CHARLES PORTER has been appointed Medical Officer of Health for the county of Shropshire in the place of the late Dr. W. N. Thurstfield.

DR. J. F. J. SMITH will deliver to-night (Wednesday) the Annual Oration of the Hunterian Society at the London Institution, Finsbury Circus, E.C.

SIR MICHAEL FOSTER has been elected Parliamentary Representative of the University of London by a large majority. We congratulate him upon this well-merited distinction.

DR. MARIO NASCIMENTO, a Portuguese doctor, lately Mayor of Laurenço Marques, has volunteered his services in the British ambulance in Natal, and has been accepted.

DR. JACKSON, one of the few medical men who could boast of the possession of a castle, has just lost Billister Castle, in Northumberland, by fire. Fortunately no loss of life was caused.

DR. RONALD ROSS writes to the *Times* to establish his claim to priority over certain Italian observers in the cultivation of the parasite of malaria in human beings and birds.

DR. JOHN BEDDOE and his wife have furnished six cottages at Bradford-on-Avon for the reception of convalescent women and girls, who will be received in return for a nominal payment weekly.

DR. JAMESON, Director-General of the Army Medical Service; Surgeon-Lieutenant Colonel Sloggett, and the Assistant-Surgeons and Dressers of the Imperial Yeomanry Hospital, were presented to H.R.H. the Prince of Wales, at Marlborough House, on Friday last.

PROF. BOYCE, of University College, Liverpool, has been reappointed Municipal Bacteriologist to the City, subject to a month's notice. An amendment providing for a year's notice was withdrawn, although a month's notice certainly seems very short for a post of this importance.

DR. WEATHERS, Police Surgeon for Sheffield, has volunteered for service in South Africa. He is a well known shot, and can ride well, and the Guardians, in consideration of his patriotic spirit, have decided to keep his appointment open until his return from the seat of war.

MR. WILLIAM HENRY POWER, principal Medical Officer to the Local Government Board, has been appointed a member of the Royal Commission on Sewage Disposal, vice Sir Richard Thorne Thorne, deceased. Sir Thomas Lauder Brunton, M.D., F.R.S., had the honour of Knighthood conferred upon him by Her Majesty the Queen, at Osborne, on Friday last.

WE learn with satisfaction that Mr. G. J. Johnston, Surgeon to the City of Dublin Hospital, who had been infected with diphtheria is, under the care of Dr. Parsons, making steady progress. Mr. Johnston received the infection, which was afterwards diagnosed by bacteriological examination, when operating for tracheotomy in the hospital. We hope for his early convalescence.

DR. MACWEENEY, Professor of Pathology in the Catholic University, and Pathologist to several Dublin Hospitals, and Examiner in the same subject at the Royal University, has been appointed to be Bacteriologist to the Local Government Board for Ireland. This is the first time that such appointment has been made for Ireland, though the analogous position has existed in England for some years. One of his chief duties will be to be responsible for the purity of the calf lymph now being issued by the Irish Board for general vaccination in Ireland.

MR. CHARLES STONHAM, F.R.C.S., Surgeon to the Westminster Hospital and Surgeon-Captain in the Middlesex Yeomanry Cavalry, has been appointed Senior Surgeon to the Imperial Yeomanry Hospital, and will shortly proceed to the front accompanied by a staff of dressers. During his absence from the Hospital the Lectures on Surgery will be delivered by his colleague, Mr. Walter Spencer, M.B., F.R.C.S. The staff will be somewhat short-handed in consequence of the departure of Mr. Stonham and Mr. Turner, and it is probable that one or more temporary assistant surgeons will be appointed. Many of the Hospitals are similarly situated, and there is a good opening for junior surgeons of Hospital rank.

Scotland.

[FROM OUR OWN CORRESPONDENT.]

EDINBURGH AND A BASE HOSPITAL FOR SOUTH AFRICA.—The surgical section of the profession in Edinburgh is at present much interested in the proposed formation of a base hospital to contain 100 beds, and to be entirely officered by surgeons and nurses from Edinburgh, for South Africa. The Lord Provost of the City, who has shown the best form of patriotism since the war began, obtained from the War Office an assurance that the offer of a hospital from such a centre of medical teaching as modern Athens would be most acceptable. At present no details of the proposed scheme have transpired, but as Professors Chiene and Annandale and Dr. Joseph Bell are taking a keen interest in it, and as surgical experts are numerous in Edinburgh, provided the matter of expense can be arranged there should be no difficulty in the way in regard to a staff. Edinburgh is largely represented at the front by combatants, commissioned and non-commissioned, but as yet has not supplied any surgical unit, apart from her graduates in the Royal Army Medical Corps.

FUNERAL OF THE LATE PROFESSOR SIR THOMAS GRAINGER STEWART.—On Wednesday last the funeral of Sir Thomas Grainger Stewart took place, the preliminary service being held in St. George's Church (with whose affairs the late professor was for long officially connected), prior to the final ceremony in the Dean Cemetery. The members of the medical profession in Edinburgh were present in large numbers to show a last token of their respect for one who had so long occupied such a prominent position among them, and had so ably discharged his duties. The Senatus of the University, the Royal College of Physicians of Edinburgh, the Medical Missionary Society, and the Students' Representative Council attended officially, while included among the senders of wreaths were the annual Presidents of the Royal Medical Society, the Students' Union, the infirmary residents, the physicians, students, and nurses of his infirmary wards, and the students' attending the class of Practice of Physic in the University, the numbers of these tributes of esteem coming from undergraduate sources testifying to the regard felt by the medical students at the University of Edinburgh towards their late teacher.

THE VACANT CHAIR OF THE PRACTICE OF PHYSIC IN THE UNIVERSITY OF EDINBURGH.—The Curators of the University of Edinburgh will have shortly thrown upon them the unenviable task of deciding upon whom the Chair of the Practice of Physic, rendered vacant by the recent death of Sir Thomas Grainger Stewart, shall be conferred. Among the many worthy physicians who will certainly become candidates for the post, which has before now been termed the "blue riband" of the teachers of medicine, it must prove an onerous task to weigh impartially the numerous pros and cons, the individual merits, and the promises for the future presented them.

At present we know of three certain candidates, John Wyllie, M.D., F.R.C.P.E., M.R.C.S., LL.D.; Bryon Bramwell, M.D., F.R.C.P.E., F.R.S.E.; and George Gibson, M.D., D.Sc., F.R.C.P.E., F.R.S.E., given in order of seniority. All three have an established reputation far beyond the limits of their own sphere of labour, all have conducted extra-mural classes upon Practice of Physic with success; for many years have or have had infirmary posts, and have published various works in medicine of world-wide fame.

The principal question will come to be whether a professorial chair is best filled by one who has passed the years of middle life, and has achieved success which his age suggests may be continued, but will probably not be surpassed, or by the middle-aged, already successful, with a promise of increased ability in the future.

We understand that the official staff at the Royal Naval Hospital, Stonehouse, is to be increased by one Deputy-Inspector General, and one more surgeon.

Manchester.

[FROM OUR OWN CORRESPONDENT.]

THE FUTURE OF THE ROYAL INFIRMARY.—The old problem is ever new. Men and years come and go, and the ancient hospital stands, and we "muddle through," hoping for better times. But new buildings, adequate equipment, sufficient endowment, remain dreams of the future. Professor Leech has recently contributed important articles to the *Manchester Guardian* in a strenuous effort to answer the question, "How should the additional accommodation required at the Manchester Royal Infirmary be provided." He brings a grave indictment against the present building clearly indicating its present deficiencies, and the unavoidable crippling of the work of the institution. The main departments of the hospital are not now in size or equipment fitted for the claims upon them, and great additions and changes are required, patients are discharged from the infirmary before they are fit to go out, in order to find place for others more seriously ill. A certain number of patients have to be sent to the Union hospitals because the necessary requirements for their treatment at the infirmary cannot be provided. The admission into the wards of patients suffering from accidents has been greatly restricted. Patients suffering from serious ailments requiring admission into the Infirmary have often to wait a long time before they can be admitted, and sometimes suffer gravely in consequence.

Instances from time to time occur in which serious accidents and cases urgently ill are brought to the Infirmary, requiring immediate admission, but owing to want of room they have to be taken elsewhere. Operations are sometimes performed in the Infirmary on patients coming to the out patients' department, although the pressure on the beds prevents them being received as in-patients. This is some of Dr. Leech's evidence of the need for immediate action. He advocates re-building on a site outside the city. The annual general meeting of trustees was held on Friday last, at which it was explained that the negotiations with the Corporation respecting the sale of the Infirmary site had completely broken down.

The following resolution was then adopted:—"That the trustees hereby authorise the board of management to appoint a committee to deal with the last resolution of the Medical Board as given in the annual report, with a view to ascertain (1) whether or not a hospital suitable in every way can be built on a plan other than the pavilion; and (2) if this be decided in the affirmative by such committee, that the board of management be authorised to take steps to obtain suitable plans and estimates, and to incur all necessary expenses in connection therewith." This indicates that no immediate steps are likely to be taken in meeting the urgent necessities of the sick poor, and providing means for the adequate teaching of medical science in Manchester for some time to come.

MEDICAL SOCIETY OF LONDON.

THE meeting on Monday last was a "clinical evening," with an unusually rich supply of living specimens.

Mr. Wallis showed a small boy, who, after recovery from tuberculous peritonitis, developed acute intestinal obstruction, which had been relieved by bringing out a coil of small intestine. This had prolapsed, and the discharge had caused maceration of the skin. He excised the piece of intestine, suturing the divided ends, and solid union had resulted.

Mr. Jaffrey showed an interesting case of urticaria pigmentosa in a child, eighteen months old, the site of the wheals being marked by a brownish discoloration.

Dr. Chapman showed an obscure case of congenital cyanosis without morbus cordis, and Sir Hugh Beever showed a man, set 23, who exhibited in a marked degree the phenomenon known as *pulsus bisferiens*.

Mr. Barker having shown a case of congenital dislocation of the hip and discussed the value of forced

reduction, Dr. Ewart and Dr. Willock showed contrivances having for object the application of pressure to the thorax during expiration for the relief of emphysema.

Mr. Battle showed a man, æt. 29, with a curious deformity and tumour of the left thigh which he took to be due to osteitis deformans affecting only one bone.

Dr. W. J. Hadley showed a child with osteo-arthritis following repeated attacks of rheumatic fever with the characteristic enlargement of the spleen and lymphatic glands. He also showed another girl who exhibited some rare manifestations of rheumatism.

Mr. W. McAdam Eccles showed two cases illustrating variations in inguinal herniæ due to abnormal descent of the testis. Case 1. A man, æt. 23, with imperfect descent of both testes and a large interstitial hernia which was treated by the application of a truss and had almost disappeared. The right testis lay in the inguinal canal just above Poupart's ligament, and the left was just protruding through the internal abdominal ring. Case 2. A man, æt. 42, presented a well-marked cruro-scrotal hernia, i.e., an inguinal hernia which, escaping from the superficial abdominal ring, had missed the entrance to the scrotum and had stretched to the skin forming the junction of the thigh and the scrotum, the most external covering of the hernia being therefore ordinary skin.

Mr. Barker pointed out that in some cases at any rate the relations and position of the testis had nothing to do with the development of the hernia.

Lastly, Dr. S. Mullick showed a man, æt. 22, with transplantation of the viscera, the heart and stomach being on the right side and the liver on the left.

Obituary.

MR. THOMAS PURCELL, M.R.C.P., OF DUBLIN.

WE regret to announce the death of this respected practitioner, which took place last week at his residence in Dublin. He was the eldest son of the late Judge Purcell, who acted for a long period as standing counsel to the Irish Medical Association, and Mr. Purcell took an active part for many years in the administration of the Association. He received in 1863 his first qualification as licentiate of the Irish Colleges of Physicians and Surgeons, and took the higher diploma of the latter body at a later date. He was for many years, until his death, a medical officer of one of the South Dublin Dispensaries, which coveted position becomes vacant by his death.

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

NEALE'S DIGEST.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—No doubt most of your readers are aware that Dr. Neale has recently published the Supplement to his "Medical Digest," which completes and brings down to date that admirable guide to the British medical literature of the last fifty years: but it is not likely they have any idea of the enormous and unremitting labour this self-imposed task has cost the compiler. The work of making his index, and preparing it for the press has involved an average of four hours per day for more than fifty years! This labour has not only been without remuneration, for the publication of the Digest has never been profitable, but it has been carried on year after year at great cost to Dr. Neale, who, with rare determination has cheerfully persevered in a task which he originally undertook for the benefit of science and of his profession rather than for his own pecuniary advantage.

It seems to the undersigned that it would be unbecoming to the profession he has worked for if Dr. Neale's labours were allowed to pass unrecognised, and they have, therefore, decided to invite the members of

the profession throughout the British Empire to contribute to a fund which will enable them to present Dr. Neale with a suitable testimonial, as a recognition by his professional brethren, of his long continued and invaluable labours on their behalf. Obviously, it would be premature to discuss the form of the testimonial until the amount of the contributions can be ascertained, but all the subscribers will be communicated with before a decision is arrived at.

W. S. CHURCH, President of the Royal College of Physicians.

WM. TURNER, President of the General Medical Council.

H. G. HOWSE, Senior Vice-President of the Royal College of Surgeons.

THOMAS BRYANT, President of the Royal Medical and Chirurgical Society.

R. DOUGLAS POWELL, President of the Clinical Society.

W. WATSON CHEYNE, President of the Pathological Society.

FREDERICK T. ROBERTS, President of the Medical Society.

ALBAN DORAN, President of the Obstetrical Society.

W. H. BROADBENT, President of Medical Graduates College and Polyclinic.

HENRY POWER, President of the New Sydenham Society.

JONATHAN HUTCHINSON, Hon. Secretary of the New Sydenham Society.

Subscriptions may be sent to Mr. J. Y. W. MacAlister (Librarian of the Royal Medical and Chirurgical Society), 20, Hanover Square, London, W. It will save him much trouble if cheques are made payable to "Bearer" and crossed "National Provincial Bank—Neale Testimonial Account."

THE IRISH CONJOINT EXAMINATIONS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—May I be permitted to correct a statement in the current number of your journal, that the report of the Committee of Management on the autumn examinations has been held over for nearly three months. It is not possible to make up the statistics of an examination till said examination shall have concluded. The examinations to which the report relates were not completed till November 10th, and the report was forwarded to the Royal College of Surgeons on December 13th—just one month, not three.

There was no meeting of the committee between November 20th and December 11th, so that the report was presented and passed at the earliest possible moment.

I am, Sir, yours truly,

GREENWOOD PIM, Sec.

Dublin, February 9th, 1900.

THE ALLEGED FAILURE OF ISOLATION HOSPITALS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—One cannot help wondering why you went out of your way to make such an effort to break my poor butterfly on the editorial wheel.

Your "review" of my hapless pamphlet appears more like a personal attack than a criticism. You characterise the language used as odd, and proceed to justify your assertion by making a gross misquotation, which is very odd indeed.

"Serious argument," you say, "is conspicuous by its absence." Oh! In the *resumé* on page 12 I summed up the case against hospital isolation thus:—

1. The danger of secondary infection.
2. The failure as instanced by "return cases."
3. The high mortality of "return cases."
4. The danger of "catching" other diseases.
5. The injury inflicted on children by removing them from home influences.
7. The demoralisation which follows in the train of rate-supported free hospitals.
8. The fact that the period during which houses remain centres of infections, was trebled, quadrupled, and sometimes sextupled by "return cases."
9. The utter and complete failure to control epidemics.

I also gave our experience in Nottingham of the stamping-out process, which is as follows:—We began in 1883 with 428 cases, in 1889 we had 1,047, in 1895 1,250, and up to the end of November last year 2,383.

If this be not "serious argument" in your opinion I cannot help it. You say "the author propounds no alternative scheme." I am surprised at this. If a man brings to demonstration a particular scheme is it contended that he is bound to provide an alternative scheme?

I protest against your discovering my supposed motive. In this you go beyond the bounds of legitimate criticism. My pamphlet appeared in December. Everybody knows that the municipal elections are over and forgotten by the end of November; then how can it be said that my pamphlet was written for electioneering purposes.

The failure of isolation hospitals is everywhere meeting with wide recognition, and it affords me astonishment that you seem to be unaware of the fact.

I am, Sir, yours truly,

EDWD. DEAN MARRIOTT.

Nottingham, February 7th, 1900.

[As Dr. Marriott does not refer us specifically to the alleged "gross misquotation," we are unable to verify or explain. Dr. Marriott's conclusions are clear enough, but when we commented on the absence of "serious arguments," we referred to the grounds on which those conclusions were advanced. The latter we still regard as quite inconclusive. With reference to his complaint that we suspected a desire to influence local politics we believe we are correct in saying (the pamphlet having gone the way of most pamphlets) that the author wound up by stating that it remained with the voters to remedy a condition of things which he regarded as an iniquity. This surely constitutes an appeal to the electorate!—Ed.]

The Royal University of Ireland.

At a full meeting of the Senate, held on Thursday last, a resolution of sympathy with the Marquis of Dufferin and Ava, K.P., Chancellor of the University, on the death of his son, the Earl of Ava, was unanimously adopted.

A committee was appointed to examine the financial state of the University, with the view of ascertaining how far it would be possible and desirable to appoint additional and external examiners; and the standing committee were requested to report as to the qualifications to be required for honorary degrees.

The following gentlemen were recommended to the Vice-Chancellor for nomination to the two commissions in the Royal Artillery placed at his disposal by the Secretary of State for War:—(1) C. W. Nixon, (2) S. Perry, and, in case either of these gentlemen fails to qualify, (3) H. J. Nolan-Ferrall.

The following appointments were made:—

FELLOWS (for five years).—Rev. Henry Browne, T. W. Dougan, C. H. Keene, James MacMaster, Thomas P. O'Nowlan, Philip Sandford, Thomas Arnold, Rev. J. Darlington, S. J. MacMullan, G. F. Savage-Armstrong, William F. T. Butler, E. Cadic, V. Steinberger, Rev. E. Hogan, Rev. T. A. Finlay, William Magennis, John Park, William P. Coyne, Alfred C. Dixon, J. J. Gibney, H. C. McWeeney, John Purser, William B. Morton, Thomas Preston, J. H. Stewart, E. A. Letts, Hugh Ryan, B. O. Cunningham, and George Sigerson.

MEDICAL FELLOWS (for three years).—A. Birmingham, J. P. Pye, J. Symington, J. J. Charles, D. J. Coffey, John I. Lynham, P. J. Hayes, and Sir Thornby Stoker.

EXAMINERS (for the year 1900).—Douglas Hyde, Rev. R. H. F. Dicky, W. J. Carbery, Rev. R. J. Semple, Rev. G. Woodburn, William Graham, Alexander J. M. Blaney, Marcus M. Hartog, Richard J. Anderson, Alexander Jack, M. F. Fitz Gerald, Annie W. Patterson, Joseph Smith, Charles F. Doyle, William N. Watts, William A.

Houston, William Bergin, Joseph F. O'Carroll, James A. Lindsay, William H. Thompson, E. J. McWeeney, J. Lorrain Smith, John W. Byers, Alfred J. Smith, C. Y. Pearson, Antony Roche, F. J. B. Quinlan, William Whitley, Arthur W. Sandford, Louis Werner, and Sir Charles A. Cameron.

At a public meeting of the University the Degree of Bachelor of Arts was conferred on William Moloney Margaret College (S. J.), Limerick.

Royal College of Surgeons in Ireland.

A MEDICAL Students Guide for the coming session has just been issued by the College. The preliminary examinations are held in March and September. The conjoint professional examinations are held in the months of April, July and October.

The Conjoint Diploma in State Medicine.—Held the first Tuesdays in February, May, and November. Fee, £10 10s.

The Fellowship Examination.—Held the third Mondays in February, May, and November. Fee, £26 5s.

The Licence in Surgery for Registered Practitioners.—Held the first Mondays in February, May, and November. Fee £26 5s.

The Licence in Dentistry.—Held second Mondays in February, May, and November. Fee Primary, £10 10s.; Final, £10 10s. Entries for all examinations must be made fourteen days previously.

The Guide can be had free on written application to the College, Stephen's Green, Dublin.

Medical Libel Suit.

AN action was tried at Kilmsnock last week, in which Dr. Beveridge, of Hurlford, claimed £1,000 damages against Dr. Baxter, also of Hurlford, for slander contained in a report sent by the defendant to the Riccarton Parish Council concerning the plaintiff's treatment of a child. The Sheriff found that the report was slanderous but privileged, but that the defendant had shown malice and want of justification, and he awarded £100 with costs.

THE anniversary dinner of the Medical Society of London will be held in the Whitehall Rooms of the Hotel Metropole on Thursday, March 16th, at 7 o'clock. Tickets may be obtained of the honorary secretaries, Dr. James Calvert and Mr. F. C. Wallis, at 11, Chandos Street, W.

Lectures at the Royal College of Surgeons of England.

THE following are the lectures arranged for the current quarter. Each is delivered at the hour of four o'clock, and all are open to members of the profession on presentation of visiting card, whether Fellows of the College or not. Mr. E. Treacher Collins, F.R.C.S.: Three lectures on "The Anatomy and Pathology of the Eye," the first of which was delivered on Monday last; the remaining two will be delivered to-day and on the 16th inst. Mr. B. G. A. Moynihan, F.R.C.S.: Three lectures on "The Anatomy and Pathology of some Rarer Forms of Hernia," February 19th, 21st, 23rd. Professor Arthur Keith, F.R.C.S.: Three lectures on "The Results of an Investigation of the Anatomy of Man and Higher Primates to determine more accurately the Relationship of Man to Living and Extinct Forms," February 26th, 28th, March 2nd. Professor A. W. Mayo Robson, F.R.C.S.: Three lectures on "The Surgery of the Stomach," March 5th, 7th, 9th. Professor C. Stewart, LL.D., F.R.S.: Six lectures on "The Protection and Nourishment of the Young in Plants and Animals," March 12th, 14th, 16th, 19th, 21st, 23rd.

Army Medical Service.

The following is an official list of successful candidates for commissions in the Royal Army Medical Corps at the recent examination in London arranged in the order of merit:—

Biggan, T.	2554	Adye-Curran, W. J. P.	2185
Richardson, H.	2532	Powell, J. L.	2156
Carr, C. H.	2490	Argles, R. L.	2080
Baker, W. L.	2462	Foster, J. G.	1975
Cotton, F. W.	2420	Lauder, F. P.	1970
Bennett, E.	2275	Ford, E. G.	1803
Parry, F. M.	2248	Walker, F. S.	1802
Dinnis, B. R.	2221	Purser, L. M.	1800
Twigg, J. S.	2185		

Notices to Correspondents, Short Letters, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a distinctive signature or initials, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

LOCAL REPORTS AND NEWS.—Correspondents desirous of drawing attention to these are requested kindly to mark the newspapers when sending them to the Editor.

READING CASES.—Cloth board cases, gilt lettered, containing twenty-six strings for holding the numbers of THE MEDICAL PRESS AND CIRCULAR, may now be had at either office of this journal, price 2s. 6d. These cases will be found very useful to keep each weekly number intact, clean, and flat after it has passed through the post.

ORIGINAL ARTICLES or LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

REPRINTS.—Authors of papers requiring reprints in pamphlet form after they have appeared in these columns can have them, at half the usual cost, on application to the printers before the type is broken up.

DR. PERCY LODGE.—We hope to have space for your case in our "Clinical Records" next week.

FEMALE MEDICAL STUDENTS IN PARIS.

THERE are actually 128 female medical students at Paris, of whom 91 are Russians, 29 French, 5 Roumanians, 2 Germans, 1 Swiss, and 1 British. In Paris women are placed absolutely on the same footing as men, and their presence has long since ceased to give rise to the ill-bred manifestations of dislike which characterise the conduct of male students in this country when mixed classes are attempted.

DR. R. GLASGOW PATTISON'S case is marked for early insertion.

DR. ALEXANDER DUKE.—If possible in our next.

DR. MERRIN.—Your communication was too long for publication in the present number, but we have marked it for early insertion.

QUEERENS.—The matter will receive editorial attention at the first opportunity. The time is not yet ripe.

DR. McV L.—Your suggestion has been anticipated, and a fund of over £12,000 is being raised in Edinburgh for the equipment of a Scottish Hospital for South Africa. Over half the sum has already been promised.

M. S.—Dr. Springer's suggestion bears on "epiphysal" culture and not, as most of the lay journals have described it, "epiphysical" culture.

DR. E. HOPE (Liverpool).—Your letter will receive attention in our next issue.

PONDEROUS INDEED!

THE Paris correspondent of the *Refrère* is responsible for the following *jeu d'esprit*:—"Is there one single man," he asks, "who would dare to be ill with this solemn fact in his face? Permission to act as a doctor has been granted by the Paris Faculty to Mlle. Marie Kritchewsky-Gochbaum, who se treatise on 'ankylose articulaire progressive et generalisee on synarthrophysae' struck them as being excellent. Fancy sending out a servant-girl with that weight to carry, and to bring back to your bedside the lady who did it, and was still going well and strong!" Bravo, *Refrère*! but all the same it would not be safe to gauge the male doctor by the ponderosity of his scientific treatises.

Meetings of the Societies and Lectures.

WEDNESDAY, FEBRUARY 14TH.

HUNTERIAN SOCIETY (Theatre of the London Institute Finsbury Circus) - 8.30 p.m. Dr. F. J. Smith: The Influence of Modern Medicine on Surgery Annual Oration.

THURSDAY, FEBRUARY 15TH.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Tichborne Street, Elgware Road) - 8.30 p.m. Papers:—Dr. G. F. Blacker: Experiences in Feeding Delicate and Premature Children with Modified Milk. -Mr. F. Jaffrey: Calculous Suppression of Urine treated by Operation.

FRIDAY, FEBRUARY 16TH.

EPIDEMIOLOGICAL SOCIETY OF LONDON (11, Chandos Street, Cavendish Square, W.) - 8.30 p.m. Paper:—Dr. E. W. Hope: Insanitary Property and Workmen's Dwellings in Liverpool.

Appointments.

ANDERSON, F. T. M. D. BRUX, F.R.C.S. Ed. Honorary Medical Officer to the Barnstaple and North Devon Dispensary.

BEGGS, J. E., B.A., M.D., D.P.H. Cantab. Medical Superintendent to the Grove Fever Hospital, Tooting, S.W.
BIRKETT, G. T., L.R.C.P., L.R.C.S. Ed. Assistant Medical Officer for the Calford Sanitary District of the Lewisham Union.
GREENWOOD, T. PARKER, M.B. C.M., B.Sc. Edin. Assistant Medical Officer to the Three Counties Asylum, Hitchin.
JONES, W. WATKINS, M.D., C.M. Ed., D.P.H. Camb. Medical Officer of Health to the Gelligerr and Rhigos District.
MORGAN, FREDERICK CHARLES, L.R.C.P. Lond., M.R.C.S. Resident Medical Officer at the Eastville Workhouse, Bristol.
NOBLE, H. PERCY M.B., B.S. Lond., M.R.C.S. Assistant Anaesthetist to the Middlesex Hospital.
PORTER, CHAS., M.D. Irel., M.R.C.S. D.P.H. Cantab. Medical Officer for the County of Salop.
POTTS, W. J., M.D. Lond., L.R.C.P., M.R.C.S. Medical Superintendent of the Parish Infirmary, Bethnal Green.
ROBINSON, ARTHUR HENRY, M.D. Durh., M.R.C.S., D.P.H. Camb. Medical Superintendent of the Islington Infirmary, Highgate.
ROW, C. M., L.R.C.P. Lond., M.R.C.S. Medical Officer for the Four Sanitary District of the Battle Union, Sussex.

Vacancies.

Bath General or Royal Mineral Water Hospital, Bath.—Resident Medical Officer, unmarried. Salary £100 per annum, with board and apartments.
Brecon Infirmary, South Wales.—Resident House Surgeon, unmarried. Salary £90 per annum, with furnished apartments, board, all found except beer, attendance, fire, and gas.
Burton-on-Trent Infirmary. House Surgeon. Salary commencing at £150, with furnished rooms in the Infirmary, and coals and gas free.
City Asylum, Nottingham.—Second Assistant Medical Officer, unmarried. Salary £150, with board, apartments, and washing.
Consumption Hospital, Ventnor.—Assistant Resident Medical Officer to the Royal National Hospital for Consumption. Salary £100, with board and residence. Immediate application to Dr. Parry. (See Advt.)
Dental Hospital of Ireland.—Two anaesthetists. Immediate applications to N. A. Shea, Esq., J.P., at the Hospital, Lincoln Place, Dublin. (See advt.)
Great Northern Central Hospital London.—Assistant Anaesthetist for six months subject to reappointment, with a small honorarium. Applications to be addressed to L. H. Glenton-Kerr, Esq. (See Advt.)
General Infirmary at Gloucester and the Gloucestershire Eye Institution.—House Surgeoncy. Salary £100 per annum, with board, residence, and washing.
Hants County Asylum, Fareham.—Third Assistant Medical Officer, unmarried. Salary commencing at £125 per annum, with furnished apartments board, washing, and attendance.
Hulme Dispensary, Dale Street, Stretford Road, Manchester.—House Surgeon. Salary £130 per annum, with apartments, attendance, coal, and gas.
Kent County Ophthalmic Hospital, Maidstone.—House Surgeon. Salary £100 per annum, with board and lodging in the Hospital.
Mercer's Hospital, Dublin. Resident Medical Officer. Applications to the Registrar of the Hospital. (See Advt.)
Mercer's Hospital, Dublin.—Vacancy on the Surgical Staff. Applications to the Registrar of the Hospital. (See Advt.)
Nottingham General Dispensary.—Assistant Resident Surgeon. Salary £140 per annum, all found except board; unmarried.
Workshop Dispensary Hospital.—Resident Surgeon. Salary £120 per annum, rooms, coal, gas, furniture, and housekeeper provided. Apply to Mr. Charles A. Whall, Workshop.

Births.

DAMAN.—On February 6th, at Oakhurst, Dorridge, Knowle, Warwickshire, the wife of Karl A. Daman, L.D.S., of a daughter.
GLADSTONE.—On February 7th, at Penryn, Cornwall, the wife of Arthur Edward Gladstone, B.A. Cantab., M.R.C.S. Eng., L.R.C.P. Lond., of a daughter.
KIRBY. On February 5th, at Maesteg, Glamorganshire, the wife of Walter Kirby, L.R.C.P. Edin., L.R.C.S. Edin., of a daughter.
PARKER.—On February 6th, the wife of G. D. Parker, M.B., Westwood, Manchester, of a son.
PORTER.—On February 7th, at 9C, Edith Road, W. Kensington, the wife of Robert Ibbetson Porter, M.A. Oxon, M.R.C.S., L.R.C.P., of a son.

Marriages.

BRACE-BROCKMAN TRAVERS.—On February 10th, at the Cathedral, Bombay, India, Capt. V. G. Drake-Brockman, Indian Medical Service, 5th son of W. Drake-Brockman, Esq., P.W.D., N.W.P., India (retired), of Cheriton, Bournemouth, to Julia Beatrice, youngest daughter of Lt. Col. J. B. Travers, of Southampton.
HUDSON-CROSSE.—On February 8th, at the Cathedral, Norwich, Edmund Hudson, M.R.C.S., L.R.C.P., third son of the Rev. W. Hudson, of Eastbourne, to Lucie Agnes, youngest daughter of the Ven. Archdeacon Crosse, Canon Norwich Cathedral.
STABB-HUNTLEY.—On February 5th, at the Church of SS. Philip and James, Cheltenham, William Wilking Stabb, M.D., of Torquay, to Mary Gertrude, only daughter of the Rev. Osmond C. Huntley, of Boxwell, Gloucestershire.

Deaths.

GILL.—On February 6th, at 8, Chester Place, Regent's Park, London, Walter Battershell Gill, M.D. Lond., F.R.C.S. Ed., aged 77.
OAKLEY.—On February 4th, at Lydart, Peppys Road, New Cross, S.E., Charles Edward Oakley, L.R.C.P., L.R.C.S. Edin., and L.M., L.F.P.S. Glasg.
WELLBORNE.—On February 2nd, at Brixton, Richard Wellborne, M.D., in his eighty-fifth year.

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No. 8.

Clinical Lecture ON THE TREATMENT OF PLEURISY.

By PROF. G. DEBOVE.

THE treatment of pleurisy, which forms the subject of this lecture, may be *pathogenic*, that is to say, directed to the cause of which pleurisy is but an effect, or on the contrary, *symptomatic*, that is to say, to act upon the pleurisy itself by medical and surgical means. I will not insist on the *causal* treatment which is that of the various maladies of which pleurisy is but a manifestation. It will suffice for me to point out to you the importance of it by two examples. In the immense majority of cases pleurisy is of tuberculous origin, and its treatment is merged into that of pulmonary phthisis. Sometimes, however, the pleurisy is of rheumatic origin, and in this event the treatment by salicylate of soda is indicated. Nevertheless in treating the cause, the medical treatment of the pleurisy itself should not be neglected. This treatment consists mainly in *counter-irritants*, *drastics*, and *diuretics*. The counter-irritants should be applied to the chest on the side affected and particularly over the seat of pain. They rapidly attenuate, and may even subdue two important phenomena: pain and dyspnoea. You may choose between dry cupping, wet cupping, leeches, chloride of methyl spray, sinapisms, or the actual cautery. Wet cupping should be reserved for cases in which the pain is very severe. Under the same circumstances the blister, which constitutes the classical medication, may also be employed. I am not, however, a great partisan of the blister for the following reasons:—It has two effects, one common to every revulsive, the other due specially to the action of the cantharides; now the action of the cantharides upon the economy appears to me to be harmful, for it is apt to give rise to boils, cystitis, and even nephritis. Moreover, if cantharides really act upon the effusion, it is not in the form of a blister that it should be employed, but in the state of cantharidine, or of cantharidate of potash. In addition, the blister presents certain inconveniences and even dangers, not to speak of the cicatrix which it leaves on the skin, it produces a wound which offers an impediment to auscultation of the patient, and it prevents our practising thoracentesis under aseptic conditions, and might even become the starting point of infection. In vain has the blister been defended by pretending that it favours absorption of the fluid, for that fact has by no means been confirmed by clinical experience. In justification of the employment of drastic purgatives in pleurisy, the following explanation has been given: the loss of serous liquid provoked from the intestine must produce concentration of the blood, which makes up for the loss by borrowing from the serum of the effusion the liquid elements which it needs. This pathology is somewhat ingenuous, but we would not offer much

objection if it were in accord with clinical observation, which proves to us that drastics fatigue the patient and never favour absorption of the effusion. Based on the same reasoning, diuretics have been recommended, but these again have never been seen to cure a pleurisy, and it must not be forgotten that a certain number of diuretics have an injurious influence on the kidney. Since counter-irritants, drastics, and diuretics cannot bring about the absorption of the liquid, it only remains for us to evacuate the fluid by surgical means, that is to say, by thoracentesis.

This operation, however, should not be practised in all patients; it should not be resorted to, for instance, in pleurisy supervening at the last stage of consumption, in purulent infection, or uræmia, unless the dyspnoea is very marked.

Age is not a counter-indication to thoracentesis; it has been practised with success on children under a year old and on very aged persons. If the liquid does not exceed a pint the operation is not necessary; if, on the contrary, the effusion amounts to a quart, it should be done, especially if there is much dyspnoea.

To avoid syncope before or after the operation, I am in the habit of operating the patient in the horizontal position and not sitting up as is usually preferred.

Let us suppose that thoracentesis is decided upon, what will be the *modus operandi*? In the earlier surgical attempts made to evacuate the fluid in pleurisy, pleurotomy was practised in the same way that we do it to-day for purulent pleurisy, but the results were disastrous. Morbid germs were introduced through the wound, transforming a serous effusion into an empyema. To-day, by observing with care the rules of asepsis, this danger can be vastly diminished, but it is useless to expose the patient to the risk, as we can operate without danger by means of the aspirator introduced into practice by Professors Potain and Dieulafoy. These aspirators have the advantage of permitting the use of fine needles, which frighten the patient less, produce less suffering, and do not leave fistulae, as when large trocars were used for purulent pleurisy.

In order not to introduce pathogenic organisms into the pleura where they would find a favourable milieu for their culture, the needle must be sterilised by passing it rapidly in a flame and placing it in boiling water for a few minutes. The skin must be carefully disinfected over the region of the little operation so that the point does not carry with it the germs which, under ordinary circumstances, are found on the surface of the skin; the parts should first be washed with soap and water, then with ether, and finally with a solution of corrosive sublimate. The puncture should be made in the fifth intercostal space in the mid axillary line. At this point the thoracic wall is comparatively thin, the ribs are sufficiently separated from each other, and one is sure to be far enough from the diaphragm not to run the risk of wounding it, while the heart and the large

vessels are out of harm's way. It has been recommended to pass the trocar a short distance under the skin before penetrating, in order to destroy the parallelism between the cutaneous wound and the pleural opening, so as to render all oozing impossible when the instrument has been withdrawn, but this parallelism is sufficiently destroyed by the retraction of the thorax after the operation. The needle should be pushed in quickly, and as close as possible to the upper margin of the rib so as not to wound the intercostal artery or nerve which run along its lower border.

In spite of these precautions it may happen that no liquid escapes, to the disappointment and annoyance of the operator; this may be due to an error of diagnosis, or to the fact that the pleurisy is circumscribed, the needle passing outside of it. Many surgeons with the object of obviating the possibility of disappointment pass in an exploring needle before operating, and I see no reason to object to this practice.

Among the accidents which sometimes follow thoracentesis I may mention: Rapid reproduction of the effusion, its purulent transformation and albuminous expectoration.

The rapid reproduction of the effusion is not due to the operation, but to the persistence of the cause which produced the pleurisy. These effusions are ordinarily of tuberculous origin, and easily become purulent. The liability to purulent transformation of the liquid is one of the great drawbacks of thoracentesis. Those who object to thoracentesis on this ground, however, are only right in part. It is certain that if the trocar introduced into the pleura morbid germs, the condition would be eminently favourable for their development. But it must not be forgotten that many effusions, notably those of tuberculous origin, are at first serous, and then spontaneously become purulent.

Albuminous expectoration follows in cases in which too great a quantity of liquid had been rapidly evacuated. The accident may assume three forms: slight, severe, grave. In the first named there will be dyspnoea, with continuous expectoration, accompanied by fits of coughing. In the severe form the expectoration is very abundant, the dyspnoea intense, auscultation reveals oedema of the lung. In the grave forms the patient succumbs rapidly to asphyxia. Many pathogenic hypotheses have been promulgated to explain the occurrence of albuminous expectoration, but it appears to be proved that it is the result of congestion of the lung, with acute oedema and serous invasion of the alveoli. The accident may be avoided by never withdrawing more than a quart of the liquid at a time. If the effusion be very abundant a second operation may be done on the following day, for thoracentesis is as benign as it is simple. There is, moreover, no objection to leaving a little liquid in the pleura, for this is sometimes very quickly absorbed without necessitating a second operation.

Among other accidents due to thoracentesis I may mention pneumothorax, wounds of the lung, cough, and thoracic pain. Pneumothorax is hardly to be feared. The introduction of a small quantity of air into the pleura during the operation is not attended by danger and is soon absorbed. A wound of the lung is not very important, but syncope is sometimes very serious when due to a too complete and too sudden evacuation of the fluid, producing rapid congestion of the lung and anæmia of the medulla as a consequence. The cough is dry and irritating, and so painful that the operator is obliged to stop. Sometimes intra-thoracic pain is produced which may become so severe as to render it necessary to suspend the operation. This pain is probably due to distension of the pleura when the compressed lung returns to its normal volume.

Original Communications.

INSTRUCTION IN OBSTETRICS AND GYNÆCOLOGY. (a)

By W. J. SMYLY, M.D., T.C.D., F.R.C.P.,

President of the British Gynæcological Society; Gynæcologist to the Adelaide Hospital.

IN this country, curiously enough, practical instruction in midwifery is generally of a most primitive description, owing chiefly to the paucity of well equipped Lying-in Hospitals, and this is the more remarkable since in comparatively insignificant towns on the Continent there are splendid Maternity Hospitals, superior to any to be found in this country, where the students are carefully instructed by professors of great learning and experience, assisted by an efficient staff of assistants. Clinical teaching can only be carried out efficiently in the wards of an hospital, but most of our students pick up what they can from attending a few women in their confinements in their own homes. What would be the position of medicine and surgery in this country if the only instruction given to students were a course of systematic lectures, and a few domiciliary visits with or without the assistance of their teachers.

As regards gynæcology the case is different. All our large hospitals possess a gynæcological department which together with special hospitals afford ample material for the practical study of women's diseases. These departments are well equipped and supplied with competent teachers, but the benefit which would otherwise be derived is nullified by the unpractical nature of the examinations. To the majority of students the chief object of study is to pass their examinations; to the diligent and ambitious to do it with credit, and rightly because their position in after life mainly depends upon their doing so. A student is well aware that in passing through that ordeal he will be brought to the bedside, and will have to diagnose the disease from which the patient is suffering. He cannot tell what part of the human body he may be called upon to investigate, but of one thing he is certain, that it will not be the female pelvic organs. He must therefore familiarise himself with the methods of examination in every other department of medicine and surgery, but the practical study of women's diseases he may safely neglect. I have found this in my own hospital work. My clinical lectures are well attended by the students, the examination of patients badly, and the operations hardly at all. I do not suggest that every student should have a practical examination in midwifery and gynæcology, though in other countries this is the case. In the McGill University, for example, a clinical examination in these subjects similar to that held in Medicine and Surgery, forms part of the final examination; but I do think that he should take his chance of such an examination, and it appears to me an anomaly that every student has to submit to a practical examination upon the eye, and no student is examined in this way upon the uterus. And this is the more remarkable because in no other branch of medicine is practical knowledge relatively more important than in this. The theory of midwifery and gynæcology is a limited subject and easily acquired, but the practical manipulations are exceedingly difficult and require much time and trouble. A practitioner who has passed his examinations with a minimum of knowledge can easily supplement it afterwards by study, but the *tactus*

(a) Abstract of the Presidential Address delivered before the British Gynæcological Society, February 8th, 1900.

eruditus can then only be acquired after much discredit to himself and possible injury to his patients.

MIDWIVES AND MONTHLY NURSES.

The education of midwives has received a large amount of attention, but is still in a most unsatisfactory condition. It is a lamentable fact that after upwards of a century of agitation nothing has been done to enforce women who undertake to attend others in labour to have any knowledge at all of their duties. During the past quarter of a century I have been brought much in contact with midwives, and as a class I have found them an honest, careful, respectable, and fairly efficient body of women. To this general rule, however, I have found exceptions, and have met with ignorant, drunken, and meddlesome women, who were a source of danger to their patients; and if this experience be multiplied by that of practitioners throughout the country, it represents a large number of ignorant, incompetent, and even immoral women. This is a condition of things which is a disgrace to our civilisation, and loudly calls for legislative reform. This question has before this been brought before our Society, and it is our duty, not only to press for reform, but so to influence the course of legislation that it may prove beneficial alike to the public and the medical profession. At the present time anyone may practise midwifery, and call themselves midwives. It should be our object to insure that in future only properly trained women should use this application, and that they should not overstep their duties by practising midwifery.

In an inaugural address as President of the Obstetrical Society in 1895, Dr. Champneys gave a clear and concise history of midwives in England, and the work of that Society in relation to their examination and registration, a history which could not be too widely circulated or too seriously considered by medical men in these countries at the present time. We should never forget, and we should not allow the public in the present agitation to overlook the fact that this movement for reform originated with, and has ever since found its most ardent supporters among the members of our profession. In 1616 Dr. Peter Chamberlain begged James I. "that some order may be settled by the State for the instruction and civil government of midwives." In his work, "A Voice in Ramah," he speaks thus:—"Because there was never any order for instructing and governing midwives, therefore there never must be; because multitudes have perished, therefore they still must perish; because our forefathers have provided no remedies, nor knew any, therefore we must provide none, though we know it." "These words," Dr. Champneys says, are unfortunately as true to-day as when they were written." In 1756, through the influence of Dr. Mosse, the Rotunda Hospital was incorporated by Royal Charter, and one of the chief objects named and reasons assigned for granting that Charter was "that by admitting and instructing in such hospital women who, after some time spent there, being duly qualified, may settle in such parts of our said kingdom as most stand in need of such persons, it will be a means of preventing the unhappy effects owing to the ignorance of the generality of country midwives. That by preserving the lives of so many infants who in all probabilities must otherwise perish it will increase the number of our subjects in our said Kingdom." In 1813 the Society of Apothecaries, in 1882 the British Medical Association, in 1890 the Midwives Institute, the Obstetrical Society and British Medical Association urged upon Parliament the necessity for legislation. A Select Committee of the House of Commons in 1892-93 recommended that a system of examination and registration of midwives should be established. I need not recall all the efforts made, and bills brought forward,

but hitherto in vain to cure what all admit is a deplorable evil.

The chief causes of past failures are, I believe:—

1. The apathy of the general public.
2. The opposition of a large part of the medical profession.
3. The exclusion of Ireland from all bills hitherto framed.
4. The difficulty of carrying any private bill through Parliament.

The first cause of failure is slowly but certainly being removed. A sudden disaster, such as a shipwreck or a reverse in war, at once attracts public attention, but constant and long-established evils such as tuberculosis and puerperal mortalities are more difficult to bring into public notice, though the total loss of most valuable lives be infinitely greater.

The opposition of a large number of the medical profession demands most careful consideration, but it is, I think, on the wane, as practitioners come to see that something must be done. The cry that midwives should be ended, not mended, and that every woman should be compelled to call in a fully qualified medical attendant is absurd and impossible, and the methods adopted against those who are endeavouring to improve the education of midwives have only brought discredit upon their authors. In Dr. Champney's address, already referred to, he said "some men sometimes waked up and found themselves famous," so the London Obstetrical Society found themselves (nearly but not quite, and in a strictly professional sense) infamous. A similar charge of infamy in a professional sense was at the same time brought against myself and the Master of the Coombe Hospital, and for the same reasons, namely, that we had been guilty of doing what we were authorised by Royal Charter to do and what my predecessors had done with great benefit to the public for upwards of a century, examining and granting certificates to midwives and monthly nurses. And these gentlemen carried this matter so far as to humbly pray the General Medical Council to remove our names from the Register of Medical Practitioners. Yet there is behind this burlesque a wide and serious feeling that the State recognition of midwives would be detrimental to the interests of the medical profession and would create a new order of medical practitioners. This fear it would be folly to ignore.

It is due in the first place to experience; such a class, for it is destitute of order, does exist, and does much harm. It has existed from all time, and only comparatively recently have medical practitioners invaded its domain, yet at the present time a large and increasing number of women seek the aid of medical practitioners, and this is because they have come to appreciate the value of such assistance, and I think what Virchow has recently said with regard to quacks applies to midwives, especially the untrained and ignorant "No penal law would succeed in driving those who seek aid from *midwives* to regular practitioners. This can be hoped for from better education and greater enlightenment of the masses." Since, then, this class does exist it is idle to talk of its creation, and it would be better were all to endeavour to improve it and confine its sphere of action within safe bounds than to offer an unbending resistance to all measures of reform.

Another cause for this feeling of distrust on the part of medical men is the definition of a midwife as a person who is to attend natural labours without the aid of a medical practitioner. In England you make a sharp distinction between midwives and monthly nurses. The former undergo a longer training and severer examination, and naturally regard themselves as superior to the latter. This, I think, is unfortunate, as the midwife might consider it as degrading herself to the condition of a

monthly nurse were she to seek the aid of a medical man, and that this is not a merely theoretical objection I can prove from the experience of a friend who practices in the south of England, who was sent for by a midwife to a case of placenta prævia, but no sooner had he arrived than she immediately departed, leaving him to face a very serious situation alone and unassisted. This distinction is not only injurious, but is artificial, and impossible to carry out in practice. Should a midwife meet with a complication, as in the case to which I have alluded, she should not only send for assistance, but she should remain and assist as a nurse. A monthly nurse, on the other hand, may not be able to secure the presence of the medical attendant at the time of the birth, and she then becomes a midwife, and should have been trained as such. In Ireland we make no such distinction, and midwives are generally ready to call in medical assistance. That this is a matter of importance has been proved by the agitation for the registration of obstetric nurses instead of midwives. Personally I can see no objection to the protection of the name midwife, but I do see serious reasons for abandoning the definition that she is qualified to attend without a medical practitioner. It has been urged that it is impossible to define natural labour. This may be so, but there is no practical difficulty in defining the conditions under which assistance is to be obtained. Anyone who has had the management of an extern maternity attended by medical students or midwives has had to overcome this difficulty, and has found that a few printed rules with salutary warnings as to punishment to be inflicted in case of neglect is all that is required. In the Rotunda Hospital the student is warned that if he fails to comply with the rules, and especially if he fails to send for assistance under certain well-defined circumstances he will be liable to expulsion, and his certificate withheld. In the case of a midwife, the fear of having her name removed from the *Register* would, I believe, insure her sending for assistance under similar circumstances. In the reports of the Rotunda Hospital there are lamentable examples of cases sent into hospital too late to save life, but in my experience such neglect was the result rather of ignorance than malice, and I believe that many untrained midwives fail to send for assistance because they are unable to recognise the necessity for it. Education should precede registration, but under existing circumstances I fear we shall have to use registration as an inducement to improved education.

Now as regards our attitude in Ireland, we are strongly opposed to any measure for protecting the appellation "midwife" from which we are excluded. We have for many years educated a large number of midwives, many of whom practise in this country, and we believe that if these women were obliged to come over here to be examined and educated, the expense of travelling and living would be so great as to deter the majority from coming to us, we therefore consider it unreasonable that you should expect us to burn our own fingers in pulling chestnuts out of the fire for you. Whatever our private opinions may be, like yourselves we are unanimous in opposing any measure which we consider will injure our Midwifery School, but why should we be excluded? Do we not suffer from bad midwives just as you do? If English mothers require protection, do not Irish just as much? But as a mere matter of policy I cannot understand why those who are anxious to pass such a measure should array against it the entire strength of the Irish Parliamentary representation.

NOTE ON A CASE OF LOOSE BODY IN THE KNEE-JOINT.

By R. GLASGOW PATTESON, B.Ch., Univ. Dub.,
F.R.C.S.I.,

Surgeon to the Meath Hospital and Co. Dublin Infirmary.

THE question of the origin of "foreign," or more properly called "loose," bodies in the joints, especially the knee, is involved in so much uncertainty owing to the numerous conditions which may give rise to them, that any case bearing on a phase of their pathology is worthy of short notice.

James G., æt. 45, a carpenter by trade, came to the out-patient department of the Meath Hospital in the beginning of October, 1898. He complained of "something being loose" in his left knee, and having caused the joint to "lock," which being intensely painful at the time, had been followed by a swelling lasting for several days and preventing him from following his usual occupation. When he presented himself for examination, the synovitis had almost subsided, but no abnormal body could be felt. He stated that he was at times able to shoot the loose body out to the internal synovial pouch close to the ligamentum patellæ, and was accordingly directed to come back to the hospital as soon as either he could locate the body, or locking of the joint occurred. About a week later he returned with a fresh attack of synovitis due to the nipping of the body between the articular cartilages, and was seen by Dr. Lennon who, recognising the cause of the condition, transferred the case to me. On admission he gave the following history: For the preceding six or seven months he had suffered from time to time from vague pains in his left knee which he regarded as rheumatic, and to which he paid little attention, as they never lasted more than a few days, and never interfered with his usual occupation. It was not until about five weeks before the date of his admission that he first became aware of the association of these recurring attacks of pain with the presence of something movable in his knee-joint; and it was only when the nipping of the body in the joint had led to synovitis that he thought "something had gone wrong," and came to look for treatment. Though stating vaguely that he had always been rheumatic, there was no history of any definite attack, and the only corroborative evidence seemed to be the flitting pains which he had noticed for some months previously. There was now a considerable amount of synovitis present; but after a few days' rest and treatment in hospital the effusion disappeared, the pain departed, but no coaxing by any form of passive movement could lure the loose body from its hiding-place. He was accordingly sent home, with instructions to return at once if the body became displaced, and to avoid as far as possible all movements which might tend to drive it back again into the deeper recesses of the joint.

On October 19th, five weeks after the first sudden onset, he came up to hospital immediately after a severe attack of locking of the joint attended with the most intense agony. When the resulting effusion had subsided under treatment, a matter of a few days, the body was found lying in the position it usually assumed on coming to the surface, viz., in the inner side of the joint resting between the internal condyle of the femur, and the inner articular margin of the tibia, and directly below the anterior border of the internal lateral ligament. The limb was placed on a posterior splint and the greatest quiet enjoined. The parts were gently but thoroughly cleansed, and the surface kept for 24 hours wrapped up in a compress of glycerine and corrosive sublimate (300—1). On the following day I cut down on the loose body, fixing it firmly between the left thumb and forefinger. No attempt was made to transfix it, as my

experience is altogether opposed to such a course in the case of "free" bodies. As soon as the ill-defined border of the lateral ligament and the capsule were fully divided, the body jumped up into the superficial incision. Practically no effusion into the joint followed the operation. The sutures, of silk-worm gut, were removed on the fifth day, passive motion was begun, and at the end of a week the patient was allowed up. A certain amount of stiffness remained in the joint for some weeks, but this gradually passed away, and since then the patient has had no return of his previous troublesome symptoms.

The body when examined with the naked eye after removal appeared to consist in about equal proportions of bone and cartilage. The bony part was pyramidal-shaped, surmounted by a semi-lune of cartilage at the base which overlapped somewhat the margin of the bone. The exposed portion of the bone bore distinct traces of "eburnation," the polishing of the surface being in places very evident. The point of chief interest, however, was the original seat from which the body had developed, and the cause of its growth.

In a paper published in the *Journal of Anatomy and Physiology*, vol. xxiv., April, 1890, I discussed fully the pathology of these loose bodies in joints, directing special attention to the observations and experiments of two French observers, MM. Poulet and Vaillard, who showed conclusively how large a proportion of bodies containing bone and cartilage were derived from the outgrowths which occur in chronic rheumatic arthritis, and often affect only a single joint, and not infrequently in comparatively young individuals. These occur about the margin of the articular cartilage, and often show traces of a fibrous investment, which is continuous on one side with the periosteum and on the other with the reflection of the synovial membrane. The body was handed to Professor O'Sullivan, who kindly made a detailed examination of it. It consisted of cancellous bone and hyaline cartilage, but the latter did not show any actively proliferating zone of cells, nor was the true fibrillar splitting of the matrix, seen in chronic rheumatic outgrowths, present. The microscopic appearances were, therefore, negative; but taking into account the absence of any traumatic cause, the previous occurrence from time to time of rheumatic pains, and the sudden separation of the body by natural causes apart from injury, it seems probable that in lieu of any other plausible causation, we had to deal with another instance of these curious "wandering osteophytes."

UTERINE MYOMA ASSOCIATED WITH TEMPORARY GLYCOSURIA AND UMBILICAL HERNIA; SUBPERITONEAL HYSTERECTOMY AND RADICAL CURE OF HERNIA; RECOVERY. (a)

By ARTHUR E. GILES, M.D., B.Sc.Lond.,
F.R.C.S.Ed., M.R.C.P.Lond.,

Assistant Surgeon, Chelsea Hospital for Women; Gynaecologist to the Tottenham Hospital.

In October, 1899, I saw Mrs. V. in consultation with Dr. A. S. Gubb, who, in examining an umbilical hernia discovered a large uterine fibroid, reaching to within two fingers' breadth of the umbilicus. Her principal symptoms were menorrhagia and frequency of micturition. She was *æt* 48, and had had one child, now *æt* 12. Menstruation had been increasing in quantity for some years, and had been increasingly abundant during the last 18 months, leaving her hardly ever free.

(a) Specimen shown at meeting of British Gynaecological Society, February 8th, 1900.

Examination confirmed the diagnosis of uterine myoma; the tumour was the size of a pregnant uterus at the fourth month, and nearly filled up the inlet of the pelvis. In view of the present symptoms, the presence of the umbilical hernia, and the risk of impaction of the tumour in the pelvis, I concurred in the view that hysterectomy was indicated, this operation allowing me to procure the radical cure of the hernia as well. She was placed in a home, and on examination of the urine, Dr. Gubb found that sugar was present, amounting to 5 per cent. She had neither thirst nor polyuria, and the glycosuria was quite recent, since a short time previously Dr. Gubb had found the urine normal. Moreover, there was no wasting, but, on the contrary, the patient was a stout, florid woman with very fat abdominal walls. We therefore decided that the sugar did not mean diabetes, but was probably of functional origin, due to the nervous apprehension of the operation manifested by the patient. Under the circumstances I did not regard the glycosuria as a contra-indication to operation. On Nov. 3rd I performed a sub-peritoneal hysterectomy. The incision was carried up above the umbilical hernia, which was first dealt with by excision of the sac, and the uterus was then removed in the usual way. The operation was rendered rather difficult by the thickness of the abdominal walls, but otherwise presented no special features. The ovary and tube were left on one side. Recovery was uneventful, and the patient left the home well, three weeks after the operation. Sugar persisted in the urine for a week after operation, and then disappeared. It has not reappeared since.

I do not know of an instance in which a uterine myoma has been recorded as complicated with glycosuria; the association of glycosuria with ovarian tumours has been noted, and I may refer to an interesting case reported by Halliday Croom (a). In that case the patient presented other symptoms of diabetes, and the condition was regarded by Halliday Croom as being due directly to the presence of the tumour, by pressure, disturbing either the pancreatic functions or the hepatic circulation. I do not think that in my case the glycosuria was due in any way to the tumour, for two reasons, first, because the sugar in the urine was of quite recent occurrence; secondly, because in that case one would expect glycosuria to be more frequently found with large myomata.

This case shows that glycosuria is in itself no contra-indication even to so grave an operation as hysterectomy. Wallace has recently shown (b) that it is in many cases a positive indication for operation in cases of gangrene. He regards the glycosuria as due in these cases to a septic process; and believes that many cases of chronic suppuration are on the verge of glycosuria. If these various views be correct, then, in addition to the usually accepted causes for glycosuria (pancreatic or hepatic disturbances) we may put down pressure of tumours (Halliday Croom), septic absorption (Wallace), and functional nerve disturbance, as in my case.

Clinical Records.

CASE OF A VERY DISTENDED PYO-SALPINX OF THE RIGHT SIDE, THE OPPOSITE TUBE DISTENDED AND THICKENED, UTERUS REMOVED BY SUB-PERITONEAL METHOD. RECOVERY. (c)

By F. A. PURCELL, M.D., M.Ch.,

Surgeon to the Cancer Hospital.

E. C., from Newport, Mon., *æt* 36, married, was

(a) Halliday Croom, *Brit. Gyn. Jour.*, Vol. 11, p. 476.

(b) Wallace, *Lancet*, December 23rd, 1899.

(c) Read before the British Gynaecological Society, Feb. 8th, 1900.

admitted to the Cancer Hospital August 28th, 1899, complaining of a lump in lower abdomen, causing great pain. Not been well for thirteen years. Mother of two children. Her mother died of cancer.

About thirteen years ago she had a yellowish discharge from the vagina, accompanied by great pain in the womb, for which she sought treatment at Winchester Hospital for eight weeks. She was told there the womb was prolapsed and was given an instrument to wear. Three years later the same thing happened and she returned to the hospital for seven weeks; she was unable to wear the instrument. Seven years ago the same occurred in India; again three years ago, and every winter since. She now complains of great pain and swelling in the pelvic region, menses irregular in time and quantity during last six months, as occurred during previous attacks; frequency and difficulty in micturition; urine, sp. gr. 1014 acid, no albumen, tongue furred, dyspeptic; bowels constipated, defecation painful, except with liquid stools, abdomen not distended, muscles held rigid, tender on pressure.

Per Vaginam.—Tumour felt in pelvis, pushing cervix to anterior vaginal wall, it cannot be isolated from uterus. Per rectum, the tumour is felt impacted in Douglas's pouch and undoubtedly cystic, on consultation laparotomy was decided upon.

Operation, September 27th, 1899.—Having been duly prepared she was anaesthetised by means of gas and ether, the abdomen was opened between umbilicus and pubes to the side of the linea alba, through the fibres of the rectus muscle, patient was then raised into the Trendelenburg position, a large fluctuating tumour found occupying the right side of the pelvis, being about the size of a fetal head of six months' gestation, firmly agglutinated to side of uterus, old standing adhesions with thick organised lymph bound down the caecum, the uterus normal size pressed over to the left; the left tube lay much enlarged and thickened, bound down with organised lymph. The caecum was freed, and in tracing the appendix it was found bound down and stretching across Douglas's pouch to the right, three inches long and attenuated; this was freed and removed. An attempt was made to enucleate the tumour, but it was found impossible to separate it from the uterus; in the manipulation the cyst burst, and gave exit to a large quantity of thick pale pus; some escaped into the abdominal cavity. Total removal of the uterus was then decided upon and carried out by the subperitoneal method; an iodoform gauze drain was passed down the canal of the cervix and os into the vagina; the sigmoid flexure rose up behind the uterus, hard and tense and resembled a fibroid, but was recognised as intestine; the stump of the cervix was not sutured together, no blood was lost; the pelvic peritoneum was carefully stitched across with catgut. The abdomen was then freely flushed out with warm saline fluid, some gallons used, to wash out the pus that had escaped. No drain was inserted beyond the gauze already mentioned; a single row of silkworm gut sutures was used to unite the abdominal wall. Patient made a good recovery, and left hospital much improved in every way, looking stouter than when admitted.

The specimen presents a large sac now much contracted from the spirit solution, so that its size *in situ* can hardly be surmised. After removal it was found to be impossible to free it from the side of the uterus. The opposite tube is to be seen enlarged and thickened; the ovaries were allowed to remain. The question I should much wish answered is, was it feasible to enucleate the sac? And was I justified in removing the uterus?

CASE OF CHRONIC TOTAL INVERSION OF THE UTERUS. (a)

By F. WINSON RAMSAY, M.D., F.R.C.S. Ed.,
Bournemouth.

L. S., married, æt. 48, admitted to R. V. H., December 28th, 1898, suffering from incontinence of urine and chronic uterine trouble.

(a) Read before the British Gynecological Society, Feb. 8th, 1900.

History.—Always well and healthy, had several children, last child born fourteen years ago; had normal labour, but the doctor had to peel off the placenta. Three days after labour, had castor oil, and while on the bed pan, the uterus came out into the pan. Doctor arrived within three-quarters of an hour, pushed it back into vagina, and kept it there with a pad and bandage; no excessive hæmorrhage. Seemed to have a swelling inside vagina, which gradually felt better, was able to get about and do some work, but from that day has always had a little bloody discharge. About twelve months after consulted a doctor, who introduced a Zwanck's pessary, which gave some relief; patient took it out once a week for cleaning. In March, 1898, a larger pessary was given her, and as she still complained of pain in back and bearing down, she was told not to take it out so often. In May, 1898, patient noticed that the water was always running away from her.

In September, 1898, patient was unable to remove the pessary. The doctor told her it was covered with a deposit of gravel, and it had to be broken in pieces and removed under chloroform. After removal of the pessary water ran away more than ever.

Examination.—Revealed at once a completely inverted uterus, not much larger than a normal uterus, and covered with stinking slime and phosphates; the base of the bladder was completely gone, exposing the fundus, and the edges were composed of a ring of dense cicatricial tissue. After rendering as aseptic as possible, uterus was removed with a pair of scissors on January 3rd, 1899. Operations for closing fistula February 18th, March 22nd, April 11th, June 13th, July 12th, August 15th. After operation required to empty bladder about every half hour. Now quite well, does all her work, can go easily three hours every day, and never gets up at night. Expect further improvement still.

Transactions of Societies.

BRITISH GYNÆCOLOGICAL SOCIETY.
MEETING HELD FEBRUARY 8TH, 1900.

W. J. SMYLY, M.D., President, in the Chair.

SPECIMENS.

DR. ARTHUR GILES showed a specimen of uterine myoma removed by subperitoneal hysterectomy from a patient with glycosuria, the notes of which will be found under "Original Communications."

DR. WILLIAM TRAVERS observed that the glycosuria in this case was probably functional. He would like to ask what were the symptoms that called for the operation of hysterectomy, apart from the presence of the glycosuria, since apparently the latter was in no way due to the tumour. At the present time, when the question of operation for fibroids was being largely discussed in the medical press, it was very important to know the reason for operation in each case.

DR. MACNAUGHTON-JONES said that though a relationship between ovarian tumour and diabetes or glycosuria had frequently been noticed, it was not so with regard to myoma of the uterus. Post-operative glycosuria was not uncommon, and after ovariectomy its disappearance had been explained by the emptying of the large veins and a consequent anæmia of the liver, as interference by pressure with either the portal or the hepatic artery might cause it. In the case of the uterus it was different. In ovarian tumour there might be pressure on the pancreas, but these causes were not present in the case of a myoma unless it were of an exceptionally large size. In Dr. Giles' case he should regard the glycosuria either as a coincidence or as a result of a reflex nerve irritation, and that there was here no relationship as of cause or effect.

DR. HEYWOOD SMITH agreed with Dr. Giles that the glycosuria in this case was probably due to impression on the patient's mind; although it was to be remembered that pressure effects might result from even a relatively small tumour.

Dr. W. H. BOURKE asked whether in this case the glycosuria was quantitatively estimated?

Prof. W. JAPP SINCLAIR (Manchester) observed that there were many points in this case in which more facts were desirable; for example, the amount of urine passed during the time that glycosuria was present; the relation of glycosuria to meals, and the time of day, &c. On what grounds did Dr. Giles say that the case was not one of diabetes? In his experience, when sugar had been constantly present in the urine, the patient had always died.

Dr. INGLIS PARSONS said that it was a matter of some importance whether the patient was very stout or not. There was a stout type of women who had glycosuria, not because of the existence of diabetes, but because of the dietetic habits. In a case of true diabetes, the condition would be a bar to operation. He judged that Dr. Giles' patient came under the first category.

Dr. GILES, in replying, said that the case was not one of diabetes, since there was no thirst, polyuria, or wasting. He regarded the glycosuria as of purely nervous origin, and as in no way related to the presence of the tumour. His main purpose in reporting the case was to show that glycosuria was in itself no contra-indication for operation. In reply to Dr. Travers, the grounds for interference in this case were menorrhagia and pressure symptoms. As would be seen from the specimen, the tumour was just about large enough to fill up the pelvic inlet.

Dr. F. A. PURCELL showed a specimen of large pyosalpinx, together with uterus, removed by subperitoneal hysterectomy. Full notes thereof will be found under the head "Clinical Records."

Prof. JAPP SINCLAIR remarked that if it was justifiable in this case to leave the ovaries, they must have been healthy; and if the ovaries were healthy, whatever the condition of the tubes, the best operation would have been vaginal incision and drainage.

Mr. FURNEAUX JORDAN considered that the treatment to be adopted depended largely on the condition of the tube of the other side, for unless there was much disease of the other tube, he did not think that they would be justified in removing the uterus. When the adhesions were so great that they could not be separated, it was better to incise through the vagina and drain. In such cases there was always a history of repeated attacks of peritonitis, and this would lead to a correct diagnosis. He did not see how it could be necessary to remove the uterus. It was all very well to say that the uterus was no good; but even if the woman could neither bear children nor menstruate, he still saw no advantage in removing the uterus as long as drainage was possible. He would make an exception in a case where the sac burst, and it could not be removed without removing the uterus. In any case he thought that the vaginal route was the best.

Dr. MACNAUGHTON-JONES said that as Professor Japp Sinclair and Mr. Furneaux Jordan had spoken against removal of the uterus in cases of extensive pyosalpinx, it might be well to hear a word on the opposite side of the question. At the International Congresses it was incontrovertible that the majority of continental and American authorities had decided in favour of salpingo-hysterectomy in cases of pelvic suppuration and double pyosalpinx, and the same might be said of the International Gynaecological Congresses. In the route by posterior colpotomy the complete removal of such suppurative adnexa was often most difficult, if not impossible. Salpingo-hysterectomy in such cases, without materially increasing the risk, facilitated the complete removal of the diseased ovaries and tubes. In abdominal coeliotomy, which in such cases he himself would prefer, he believed also that salpingo-hysterectomy was the right operation to perform. While the disadvantages of leaving the uterus were apparent, the advantages were most doubtful, for it should be remembered that in these cases the uterus was frequently the starting point of the disease, there had been old endometritis, and in a large proportion of the cases, gonorrhoea was the source of the mischief. He failed, therefore, to see the gain to the woman of leaving an unhealthy and useless organ.

Dr. INGLIS PARSONS thought that Mr. Furneaux Jordan spoke to the point when he said that if one side was healthy the uterus should not be removed. He preferred the abdominal route for dealing with pyosalpinx; at the Chelsea Hospital for Women they had found that in nearly all cases the contents of a pyosalpinx were sterile; and if a little pus escaped during the operation, it did not much matter. Certainly the possibility of this accident was no contraindication to operating through the abdomen.

The PRESIDENT said that his view was in favour of removing the uterus, because when both sides were so much diseased as in this case the uterus was also diseased; and if it were left, the patient was not cured. The pus in the tubes was not always sterile; he had found cases where it was otherwise.

Dr. PURCELL, in reply, said that if he had attacked this case by the vagina he would have got into great difficulties owing to the bowel adhesions; and the case would probably have ended fatally. The balance of opinion in the Society seemed to be that in the case of double tubal disease with uterine adhesions it was safer to remove the uterus as well. Time would show whether it was judicious to leave the ovaries in this case.

Dr. PURCELL also showed a card specimen of a fibromyoma of extraordinary shape, springing from the uterine fundus. It was a sausage-shaped mass, 10 inches long and of the thickness of a man's wrist; in its fresh state it resembled a stunted cactus plant. It was removed by subperitoneal hysterectomy from a nulliparous patient, *et. 40*, on January 10th, 1900. Convalescence was afebrile and terminated in recovery.

Dr. F. W. RAMSAY (Bournemouth) read the notes of a case of chronic total inversion of the uterus, which will be found under the heading of "Clinical Records."

In the discussion that followed, Dr. CLEMENT GODSON thought that there was no doubt that Dr. Ramsay's treatment of this case had been good throughout. It would have been useless to try to restore the uterus, in view of the condition of the bladder. Had there not been a vesico-vaginal fistula it might have been possible to reduce the inversion by means of Aveling's repositor, since this could be effected when an inversion had existed for many years. He had on several occasions restored such a uterus. Zwanck's pessary should never be allowed to remain *in situ* for any length of time, but should be removed every night and replaced in the morning. Before the introduction of colporrhaphy he had often used this pessary at St. Bartholomew's, with good results.

Dr. MACNAUGHTON-JONES said that Dr. Ramsay deserved their warmest congratulations on the issue of a class of case which was one of the most difficult to effect a cure in, and for the originality of the idea of closing so large a vesical opening by transplantation of the vagina and implantation of the uterus. The first who so utilised the uterus by the supra-pubic method was Dittel. Martin had formed a floor for the bladder with the vaginal tissue, and Howard Kelly's operation was very much the same as that mentioned by Dr. Ramsay. A Zwanck's pessary, unless carefully disinfected from time to time, and regularly removed for cleansing, was simply a mechanical contrivance for the incubation of septic filth in the vagina.

Prof. W. JAPP SINCLAIR related a case in which he found a vesico-vaginal fistula in a patient who gave a history of forceps delivery. There was a considerable loss of tissue; and it seemed to him that the only thing to do was to turn the uterus itself into the bladder. This he did, and the patient thereafter went on menstruating through the bladder without any inconvenience. This showed that the surface of the uterus as well as that of the vagina, need cause no bad results when turned into the bladder.

Dr. JAMES OLIVER thought it hardly possible that a woman with complete inversion of the uterus could have worn a Zwanck's pessary; but it was difficult to say when the inversion could have occurred in this case, but it might have happened when the pessary was removed. He had in one case removed an inverted uterus from a patient, *et. 55*, where it was the result of a small myoma.

Dr. RAMSAY, in reply, said that for the history of the case he had to depend entirely on the patient's statements; his own view was that the inversion had been present all the time, but he had some doubts on the subject, because she had seen several doctors who apparently did not diagnose that she had an inversion of the uterus.

The President, Dr. W. J. SMYLY (Dublin), then delivered his Inaugural Address, which will be found in another column.

After its delivery a vote of thanks to the President was proposed by the retiring President, who, in the course of his remarks referred to the midwives' question, which was again before the profession. The Gynæcological Society had, he said, always approached it in a fair and liberal manner. They did not object to the enforcement of a systematic course of education for midwives, or, as he would prefer them to be called, monthly nurses, for he did not believe in the necessity, as others did, for the perpetuation of the term "midwife" as applied to unqualified women. Every medical practitioner was by law a midwife, and, since such qualification had become an essential part of a registerable diploma, without which the State permitted no one to practice medicine as a registered practitioner, there was the serious risk of confusion in the public mind as between two classes of midwifery practitioners. They had to consider the question from a tri-partite point of view, one part of which could not be separated from the other two, namely, the interests of the public, the profession, and of the midwives themselves. He protested against any step which would dim the prestige or sully the traditions associated with the Obstetric art, and he appealed to the President, looking back over the long and illustrious roll of Obstetricians associated from the time of Ould, with his own school of midwifery, to say if it would not be unwise that with their eyes open they should take any step which might in the least degree be retrogressive and impair those traditions and that prestige. The Gynæcological Society had last year approached the General Medical Council by a memorial on the subject and with regard to the present Bill, and had received from the General Medical Council a reply to the effect that the lines of that memorial were those upon which the Council had always proceeded, and which had actuated the steps which it had taken. Thus it was evident that the position of this Society was practically in accordance with the views of the General Medical Council. He congratulated the President on his position in the Chair of the British Gynæcological Society, which was proud of him as its President, representing as he did perhaps the most famous Obstetric School in the world—the Rotunda Hospital of Dublin—of which he was a Past Master.

Dr. C. H. F. ROUTH, in seconding the vote of thanks contrasted the teaching of gynæcology to-day with what obtained when he was a student. He admired the liberal and tolerant manner in which the President had discussed the midwives question in the second part of his address. His own view of the matter was that they must have midwives, but that they should be put into their proper places.

The vote of thanks was carried by acclamation.

The PRESIDENT, in acknowledging it, said that one reason which induced him to bring forward the midwives' question was that in Ireland they had always refused to give any opinion on a Bill from which they were to be excluded. This was the first time that he had had the opportunity of speaking not simply as an Irishman, but as a Britisher.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF SURGERY.

MEETING HELD FRIDAY, JANUARY 19TH, 1900.

The President, Mr. R. L. SWAN, F.R.C.S.I., in the Chair.

FIRST CLINICAL EVENING.

EPITHELIOMA OF THE EPIGLOTTIS AND LARYNX.

MR. H. GRAY CROLY exhibited a male patient, æt. 42,

with a growth on the epiglottis. No history of syphilis. The patient became emaciated and suffered from considerable dyspnoea, and tracheotomy was performed a month after admission under chloroform.

Professor BENNETT discussed the propriety of any further proceeding. To remove a portion of the larynx without removing the tract of lymphatics reaching to the junction of the subclavian and internal jugular veins would be a grave matter.

Mr. CROLY, in reply, said the glandular enlargement was, to his mind, proof positive that the disease was not benign. His present inclination was to let sleeping dogs lie.

GOITRE REMOVED BY THE AID OF LOCAL ANÆSTHESIA BY COCAINE.

Mr. JOHN LENTAIGNE exhibited a patient from whom he had removed the greater portion of a very large goitre on September 4th, 1899, entirely under local anæsthesia by cocaine. The patient, J. P., æt. 20, was admitted on August 29th, suffering from a huge goitre, which consisted of three lobes, a very large right lobe, a large middle lobe, and a comparatively small left lobe, causing severe and constant dyspnoea aggravated by exertion, and it was on account of this dyspnoea that Mr. Lentaigne felt himself bound to attempt removal of the growth by means of local anæsthesia, instead of employing ether or chloroform, either of which would, in such a case, add considerably to the danger of the operation. Very little blood was lost as the vessels were tied before being cut. The goitre proved to be of the colloid variety, and the left lobe, which had been left, had shrunk since the operation to such an extent as to be now barely noticeable, and the patient was in excellent health and condition. The incision employed was the collar incision recommended by Professor Kocher.

After some remarks by Mr. CROLY,

Dr. KNOTT asked what was the total amount of cocaine used, and what time elapsed from the application to the commencement of the operation?

Mr. HEUSTON asked whether the dyspnoea was a pressure dyspnoea or a nerve dyspnoea?

Mr. LENTAIGNE, in reply, said there was very distinct pressure from behind. The cocaine was used hypodermically, and was injected along the line where the incision was subsequently made. From time to time a little cocaine was dabbed on the tissues. The total amount of cocaine used was certainly not more than $\frac{1}{2}$ gr. A 1 per cent. solution made with sterilised water, and which also contained 2½ per cent. of carbolic acid, was used.

FOREIGN BODY IN THE KNEE-JOINT.

Mr. R. L. SWAN showed a young man, æt. 22, from whose knee, two years ago, he had removed a loose cartilage in the ordinary manner at the inner side. Soon afterwards he began to complain of symptoms indicating the presence of another similar body in the joint. Nothing, however, could by the most careful examination be felt. Mr. Swan waited for some time in the hope that the body would become detached, but the constant occurrence of locking of the joint, followed by synovitis, had the effect of rendering the limb useless. A skiagraph showed the outline of a foreign body in the joint. A lateral incision at the outer side was made, but this proved inefficient. Accordingly a transverse section of the patella was made, and the body was found attached by a strong fibrous envelope to the intercondylar notch. The patient exhibited a perfect joint.

Mr. MILES asked whether Mr. Swan had drained the joint?

Mr. CROLY suggested Mr. Swan might have performed the operation by pushing the patella to one side and getting at the notch between the condyles without complicating the case.

Mr. LENTAIGNE suggested the locking of the joint and the sickening pain were due to sudden and violent strain on the ligaments.

Mr. SWAN, in reply, said he would not have ventured to operate if he had not the skiagram before him. He used two silver wire sutures for the patella. He did not drain the joint beyond the necessary cleansing in the progress of the operation.

LIGATION OF SUBCLAVIAN ARTERY FOR AXILLARY ANEURYSM.

Mr. FRANCIS HEUSTON brought forward a man on whom he had ligatured the left subclavian artery, in its third stage, for traumatic subclavio-axillary aneurysm, four years since. At the time of the operation he was *æt.* 50, and had been 20 years in the army. He was admitted to the Adelaide Hospital in February, 1896, suffering from severe pain in his shoulder, left arm, and back, which was then continuous, although it had been for some time at first intermittent. The superficial veins of the left arm were tortuous, the arm being also swollen and oedematous. The clavicle was raised by a tumour occupying the supra and infra-clavicular regions, presenting a well-marked bruit, distensible pulsation, and thrill. There was well-marked difference of the pulse in the right and left arms. The artery was ligated by catgut applied close to the outer side of the scalenus anticus muscle, the patient leaving hospital 23 days after operation, and resumed his ordinary occupation, which he has filled since without any return of symptoms.

Mr. MYLES asked whether Mr. Heuston drew the ligature sufficiently tight to break the inner and middle coats, or to destroy the circulation?

Mr. CROLY asked if Mr. Heuston had any difficulty with the lower cord of the brachial plexus or with the external jugular vein. Why did he select catgut in preference to ligatures such as ox peritoneum, which do not become absorbed too rapidly? Was the subclavian vein seen?

Mr. LENTAIGNE asked why Mr. Heuston called it a traumatic aneurysm, the blow having been received two years before its appearance?

Mr. HEUSTON, in reply, said he was able to feel the artery at the cope of the sterno-mastoid. He tied the ligature with sufficient force to rupture the inner and middle coats. The lower cord of the brachial plexus gave no trouble, and he was able to push the external jugular vein out of his way. He used catgut because it was the first aseptic absorbable material he could get. He called the aneurysm traumatic, from the fact that the man had got an injury, although it had not come on for some time, and what he found at the operation proved that he was right.

LIGATION OF POPLITEAL ARTERY FOR ANEURYSM.

Mr. ARTHUR CHANCE exhibited J. B., *æt.* 33, and married. He had had syphilis. His duties entailed the lifting of very heavy weights. Early in May last he noticed a dull pain at the back of his right knee, where a small pulsating tumour formed. On admission he was found to have in his right popliteal space a tumour about the size of a Tangerine orange, which showed all the classical signs of aneurysm. The right foot was much swollen and oedematous. The artery was exposed at its upper part by an incision parallel to the adductor magnus, tied with silk, and the wound healed by first intention. It is now six months since he has returned to his duties in the railway works, and there is no sign of trouble in the aneurysm.

Mr. CROLY asked if Mr. Chance had tried pressure before tying the artery?

Mr. HEUSTON asked if, previous to the ligation, any treatment was employed, and if so, what was its nature, and for how long was it used?

Mr. CHANCE, in reply, said he did not try pressure. One of the drawbacks of pressure in these cases was that it established a collateral circulation which often interfered with the ligature. He tied the popliteal artery—first, because the man's foot was very oedematous, and it was necessary to choose the method which would best establish the collateral circulation; secondly, because the man was young; and thirdly, because he was occupied in exceptionally heavy work. There was a considerable distance between the aneurysm and the ligature.

The Section then adjourned.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD WEDNESDAY, FEBRUARY 7TH, 1900.

DR. DUNSMURE, Vice-President, in the Chair.

DR. ALEXANDER BRUCE exhibited a man, *æt.* 33, suffering from disseminated sclerosis of two years' duration, who showed adductor clonus. All the deep reflexes were greatly exaggerated. When the patient was seated with the toes resting on the ground adductor clonus ensued, and continued for about ten minutes. Many cases of insular sclerosis had come under Dr. Bruce's care of late years; the increased number was probably to be ascribed to the epidemics of influenza.

Mr. C. W. CATHCART showed a boy, *æt.* 15, whose cæcum had been removed for tuberculous ulceration and contraction. The boy had suffered from chronic obstruction for six months, and on opening the abdomen a mass was found at the ileo-cæcal valve, which was firmly adherent to the adjacent structures. This was excised and the ends of the bowel reunited by sutures. Since the operation, six weeks ago, the patient had gained over a stone in weight. The wall of the cæcum was much thickened, and the lumen contracted to about one-sixth of an inch.

Dr. NORMAN WALKER showed a girl, *æt.* 20, suffering from an ulcer of the forearm. The diagnosis was obscure, but lay between syphilis and tubercle; the majority of the members were inclined to regard it as the latter.

Mr. F. M. CAIRD showed specimens illustrative of syphilitic necrosis. (1) Sequestrum from the upper jaw of a patient who had a hard chancre eight years before, and had been thoroughly treated abroad by inunction. (2) A large sequestrum from the upper jaw of a patient who contracted syphilis eleven years ago, and was treated in the ordinary way by mercury internally. (3) A sequestrum of the calvarium taken after death from a girl, *æt.* 20, the subject of congenital syphilis.

Mr. WALLACE showed a specimen of fracture of the lower end of the radius, with (probably) the rare forward displacement of the lower fragment.

Mr. COTTERILL showed a modification of the trephine. It was much simpler than that ordinarily in use, consisting of only two parts, which were readily separable for cleansing purposes.

Mr. C. W. CATHCART showed a method of keeping gauze dressing rolled up in balls like those in which ordinary twine is wound. The gauze could easily be cut off as required without risk of rendering the remainder septic.

Mr. CAIRD read a short note on a case of

LIGATION FOR FEMORAL ANEURYSM.

The patient was an old man, *æt.* 74, who had had a pulsating inguinal swelling for some months. In August last, the swelling increased greatly, and signs of rupture of the sac developed. When seen in October the thigh was enlarged, cold, and discoloured; there was no tibial pulse. The choice of operation lay between ligation of the external iliac and femoral artery, and the latter was decided on. As the patient refused to go into hospital, the operation had to be done, under most unfavourable surroundings, in his own house, yet, in spite of the fact that he suffered from delirium, retention of urine, and bronchitis, and utterly refused to stay in bed, he made a good recovery.

Mr. WALLACE read notes on

HEMATURIA DUE TO BILHARZIA HÆMATOBIA.

He described the geographical distribution of the disease, pointing out that in Egypt and South Africa hæmaturia was so common among boys and men as almost to pass unnoticed. In South Africa it was generally thought to be due to drinking impure water; in Egypt the parasite was believed to gain entrance by the urethra in bathing. Three cases—all young men from South Africa—had recently come under his notice. In the first case, a man, *æt.* 24, the hæmaturia had begun two months after he arrived in South Africa. Besides

the bleeding, priapism and seminal emissions were complained of—due probably to the irritation caused by the presence of the ova. The second case was a man, æt. 21, born in South Africa, who had been the subject of hæmaturia since his thirteenth year. He suffered from severe renal colic simulating that due to stone. He was examined by the cystoscope and skiagraphy with negative results, and the conclusion came to was that the colic was due to the passage of pellets of mucus. The third patient was a young man from Natal, whose only symptom was hæmaturia at the end of micturition. In such cases the ova should be sought for in the clots. The ova passed *per urethram* had terminal spines; in those passed by the rectum the spines were lateral. The bleeding usually ceased gradually after the patient left the infected district. Salol inwardly had seemed of use.

Dr. UNDERHILL had seen similar cases. In one—a young lady who suffered from severe colic—the administration of boric acid gave great relief.

Dr. IRELAND read a paper on the

INCREASE OF NERVOUS DISEASE AND INSANITY.

He alluded to a recent paper of Professor Erb, and pointed out that although modern life brought with it causes of additional nerve strain in the tendency to over-tasking at schools, in the greater demands made upon the learned professions by the advancement of knowledge, in the exciting character of many modern amusements, and in the increasing competition in every walk of life, yet the new conditions brought with them certain compensations. Men travelled more, and had more time for recreation and change of scene; their dwellings were more healthy, and the sanitary condition of both town and country was vastly improved. Drunkenness was undoubtedly less common, and the standard of living of the poorer classes was certainly better than thirty years ago. On the whole, the stress of life told most heavily on the middle classes. He wished that Professor Erb had brought forward direct evidence of the increase of nervous diseases, but it was most difficult to obtain trustworthy statistics on this point. He (Dr. Ireland) had addressed the following series of questions to a number of practitioners both in town and country:—1. Have you found that since you began to practise medicine there has been any increase in the relative frequency of diseases of the nervous system? 2. Have new forms come into prominence? 3. Have you observed any change in the type of old diseases? A good many replies to these circulars were received, the most valuable—as was to be expected—being from practitioners in the country. Of course many obvious fallacies must be remembered, but the general tenour of the answers was to the effect that the men who had practised for long in the same district and among the same class had seen no great increase in nervous disease. Practitioners in town, however, thought that a considerable increase in the less severe types—such as neurasthenia—was noticeable. Dr. Byrom Bramwell regarded disseminated sclerosis as much more common since influenza had become prevalent. The remainder of the paper was devoted to an elaborate statistical investigation of the frequency of severe nervous diseases in Scotland, and from this Dr. Ireland had come to the conclusion that organic nervous disease, suicide, and insanity were more prevalent in Scotland now than formerly, just as in the case of other countries.

The paper was discussed by Dr. T. S. CLOUSTON.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD JANUARY 25TH, 1900.

Mr. EDGAR BROWNE, President, in the Chair.

Dr. T. R. BRADSHAW showed a man, æt 24, a boiler maker, with extreme atrophy of the right trapezius, biceps, and brachialis anticus. The wasting had come on gradually, and its distribution suggested the commencement of the facio-scapula-humeral form of idiopathic

muscular atrophy, but it was possible that it was due to overuse of the affected muscles.

Dr. MAX LOWENTHAL read notes of a case of "fibrinous bronchitis."

Dr. NATHAN RAW read a paper on the

PATHOLOGY AND TREATMENT OF PNEUMONIA,

based on an observation of 1,047 cases during a period of twelve years. The general death-rate of the whole of the cases was 23·4 per cent. During the last two-and-a-half years, 317 cases of pneumonia had been admitted into Mill Road Infirmary (including, of course, all forms of pneumonia, and those dying shortly after admission) with a total death-rate of 34 per cent. With regard to the pathology of the disease there could be no doubt it was caused by a specific micro-organism, the *diplococcus* of Frænkel, influenced to a very great extent by rapid changes in climate, and a low resisting power in the individual. This low resisting power he had noticed most frequently in the chronic alcoholic who rarely recovered from a bad attack of pneumonia. Dr. Raw reviewed at length the various forms of treatment, which had been used in the past, and were being employed at present, and gave it as his opinion that no specific form of treatment influenced the progress of the disease or in any way cut it short. He was of opinion that the treatment of the future would be antitoxic, the anti-pneumotoxins being either procured by removing serum from a patient who had just recovered from pneumonia or experimentally from immune animals.

Dr. WATERS spoke of the statistics of other hospitals, the mortality in pneumonia varied, and the percentage would differ according as complicated cases were included or not. Dr. Waters had tabulated all the cases occurring in his hospital practice to the number of 151 with a mortality of 7·28 per cent. He had no doubt of chill and exposure as an exciting cause. With reference to treatment, he thought many cases would do well without much active interference, and attached much importance to nursing, dieting, and the surroundings of the patient. He had never practised venesection. He attached great value to carbonate of ammonia, and in many cases gave varying quantities of alcohol. In certain adynamic cases he thought quinine was useful, and in extreme cases had seen good results from the inhalation of oxygen, and injection of strychnine with free use of stimulants. He was in favour of mild counter-irritation, but did not approve of blistering in the early stages.

Dr. CARTER thought that on clinical grounds one must recognise two different forms of pneumonia—(1) Simple and tending to recovery; (2) Septic and very dangerous. He noted the variation in intensity of the disease in different years, and thought that there was a general epidemic influence that gave undue intensity to the disorder, instancing small-pox in 1881 and influenza at the present time. Referring to treatment he believed that where the cardio-pulmonary mechanism was seriously disturbed by the sudden invasion, as evidenced by gasping, small pulse, ashy colour, orthopnea, &c., the abstraction of a few ounces of blood relieved, and favoured recovery. There was one stage where opium was useful, viz., where there was a sudden fall of 6–8 degs. of temperature at the period of crisis with the onset of active delirium, physically, except for this fall in temperature, the patient seemed the same, the same amount of exudation being present, but vitally he was different, and a good sleep, which then may safely be produced was most restorative. In all other conditions opium was injurious. In hyperpyrexia he had seen marked improvement by a single cold bath or the application of cold cloths.

Dr. GLYNN considered that the mortality from pneumonia had been higher in Liverpool in recent years than it was 20 years ago—that deaths now were not infrequent in young people, whereas Barthez had only met with 2 deaths in 212 cases of pneumonia in subjects under 16. The rate of mortality was also influenced by the length of time elapsing between the onset of the illness and the commencement of treatment. Gripalle's figures emphasised this statement. He found that the mortality among patients admitted to the hospital on the first and second days of disease was 1 in 15, on the fourth

day 1 in 8, and on the sixth day 1 in 4. The pneumococcus, often associated with other organisms, had been found in the sputum in all of his cases of pneumonia. He discussed the value of leucocytes as an aid to prognosis, and referred to the various theories advanced to explain the crisis. In treatment he often resorted to physical measures for reducing the temperature, to large doses of digitalis for procuring sleep, or hypodermic injection of atropine, and believed in the efficacy of salicylate of soda and ammonia.

Dr. BARR made some remarks, after which the discussion was adjourned until February 8th.

MEETING HELD FEBRUARY 8TH, 1900.

The President, Mr. EDGAR BROWNE, F.R.C.S.,
in the Chair.

Mr. WM. JONES, the resident Librarian having been twenty-one years in the service of the Medical Institution, the members wishing to mark their appreciation of his services had collected a sum of £193 12s. 9d. (£95 6s. being collected by Dr. Kentoul, and £98 6s. 9d. by a sub-committee of the Medical Institution), and the President presented to Mr. Jones a cheque for that sum. Mr. Jones thanked the members, introducing some interesting reminiscences in his remarks.

THE TUBERCULOSIS CRUSADE.

Dr. NATHAN RAW proposed: "That it is desirable that a local branch should be established in Liverpool, in connection with the National Association for the Prevention of Consumption, and other forms of tuberculosis."

Dr. CARTER seconded, and the motion was carried *nem. con.*

Dr. HOPE said that Liverpool had through its City Council, Medical Institution, and Boards of Guardians, and the munificence of private individuals, taken active measures in regard to tuberculosis, but no branch of the National Association had been formed in it; and moved that the sub-committee appointed in 1898 to deal with questions on tuberculosis should be reappointed.

This motion was seconded by Dr. CARTER, and carried *nem. con.*

CASES.

Mr. C. G. LEE showed (1) a patient who had been accidentally shot, the bullet penetrating the inner and upper angle of the right orbit, traversing the orbit, missing the right eyeball, and finally lodging, as shown by radiographs, in the spheno-maxillary fossa. The boy was in perfect health, and, although the bullet was still in the head, except for a limited choroidal atrophy, appeared none the worse. (2) A youth, who had a piece of steel encapsuled with lymph lying at the posterior part of the retina. When first seen there was traumatic cataract, and the foreign body was discovered by the radiograph. The vision is now 6-12, and the eye quiet, so Mr. Lee has decided to make no attempt to remove the foreign body.

THE PATHOLOGY AND TREATMENT OF PNEUMONIA.

The adjourned discussion on Dr. Raw's paper was resumed.

Dr. HOPE said that the profession generally were agreed that intemperance predisposed to, and probably actually caused, the fatal results in many cases of pneumonia, but reference to this fact was not made in the death certificates. He had also seen in Liverpool that fatal pneumonia coincided with influenza epidemics, and that the fatality of these diseases was not associated so much directly with cold as with sudden changes of temperature.

Dr. MACALISTER, referring to the serum treatment of pneumonia, thought the argument that the crisis resulted from the production of the antitoxin, and that immediate relapse was thereby rendered unlikely was not maintained in the case of broncho-pneumonia, where fresh patches of consolidation succeeded one another, and that one attack of croupous pneumonia seemed to predispose to subsequent attacks.

Dr. ABRAM agreed with the specific infective nature of acute lobar pneumonia, and thought that our lines of treatment were unsatisfactory, mainly because they were

symptomatic, and hoped that the work of Washbourn Paul and others might give us a curative serum. He pointed out that Maraghamo has recently shown that the admixture of digitalis with nutrient media completely inhibits the growth of the pneumococcus, which afforded a valuable suggestion for curative treatment.

Dr. GULLAN noticed that the mortality in lobar pneumonia had been greater in 1899 than in the three years at the Royal Infirmary, and thought the type of the disease had been more severe constitutionally, and the local sign more extensive.

Dr. HAY referred to the influence of the alcoholic habit, and stated that out of 100 cases that he had watched two-thirds of the mortality was among the alcoholics. He considered that cardiac valvular disease, associated with pneumonia was of much less importance than degenerate myocardium, the condition of the latter being more important as a factor in the prognosis.

Dr. MACFIE CAMPBELL saw these cases at their commencement, and was responsible for their early treatment, and considered it was a much more fatal disease than it was twenty years ago; that he attributed to the influenza poison. Pleurisy was a frequent initiating symptom, and for that acetonite relieved the pain and fever. Salicylate of soda with carbonate of ammonia were his stand by; small doses of opium in the form of Dover's powder for the relief of pain. In order to clear up the point as to the influence of alcoholism on the mortality, it would be well if death certificates should pass straight from the doctor to the registrar, otherwise the practitioner was placed in an awkward position.

Dr. A. G. DAVIES thought that with careful nursing and treatment the death-rate from pneumonia should be under 10 per cent. He advocated the treatment by ammon. carb. and brandy, and would never use opium or other narcotics.

Dr. NATHAN RAW, in reply, said he had included all forms of pneumonia in his statistics, as it was impossible to classify them, he thought the death-rate of genuine lobar pneumonia was probably about 12 per cent. He thought no treatment had any effect in cutting short the disease, or to any great extent in influencing its progress. He found ammon. carb. the most useful expectorant and stimulant, and the combination of chloral and digitalis useful and soothing. Strychnine was the best drug in threatened heart failure. Oxygen was of little value, and as to alcohol, many cases did not require it, but in others it is necessary, and must be of good quality, and is most valuable.

BRADFORD MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD TUESDAY, JANUARY 16TH, 1900.

Mr. W. HORROCKS, President, in the Chair.

Dr. EURICH gave a microscopical demonstration illustrating epitheliomata.

Dr. JAMES KERR read a paper on

INFLAMED CORNEAL ULCERS,

and showed illustrative preparations, together with the record of 100 cases treated by operation. The disease is most common in dusty weather and in people following dusty occupations. It is frequently traumatic in origin. Workers in soil and stone are the most frequent sufferers. Its incidence increases rapidly with age after 35. The spreading serpiginous ulceration, which is the most serious form, is due to pneumococci, which are confined to the cornea, the deep symptoms being due to the toxins produced. The galvano-cautery and paracentesis were held to be the best treatment, while scraping of the ulcer was not advised. Great importance was attached to early diagnosis and energetic treatment.

Dr. MAJOR related a

CASE OF TRANCE

which had a fatal termination. The patient was a woman, æt. 50, and was seen in consultation with Dr. Moorhead. She lay almost as one dead, there was intense pallor of the skin, and the muscles were relaxed. The respirations

were exceedingly shallow, and the heart's impulse was very weak. The conjunctival and other reflexes were absent, and she could not be roused to show any evidence of consciousness. The onset had been rather sudden three days previously; there were at first some transient spasmodic movements of the limbs. She continued in this state about three weeks, and finally died of exhaustion. Had been fed artificially by enemata and by nasal tube. Physical examination was negative; optic discs normal. Post-mortem examination revealed nothing except anæmia of the nervous system and organs generally. The case was diagnosed as one of death trance—a very rare affection. The symptoms appeared to depend on profound functional inhibition of the nerve centres. As regards diagnosis, uræmia, diabetic coma, cerebral tumour, and hæmorrhage must be eliminated, but a case of trance declares itself in a short time. Practical considerations in the treatment of such a case are:—Examination of urine for albumen and sugar to exclude uræmic and diabetic coma. Regular nasal feeding. Faradisation of the surface of the dry skin with electric brush is worth trial. The administration of amyl nitrite. The injection of normal saline either into cellular tissue or rectum. Should death appear to take place, we must be exceedingly careful before allowing anyone to act on that supposition. It is an acknowledged fact that patients have almost been put into their coffins while in a condition of trance. The Faradic current should be applied to the muscles. Muscular contractions cease three hours after death. (Care must be taken to see that the current employed will cause contractions of normal muscles.) A case is recorded by Rosenthal in which thirty-three hours after apparent death, the muscles continued to react to Faradism, and forty-four hours after the patient awoke.

Dr. CAMPBELL mentioned a case in which the patient had twice been put into her coffin and subsequently recovered.

Dr. MITCHELL showed a specimen from, and read notes on, a case of ectopic gestation. The patient was a married woman, æt. 38, had menstruated ten days before being seen; had suffered from indigestion for six weeks; pulse 80; temp. 98.8. The illness commenced August 6th with severe pain and vomiting; it was thought to be a case of autumnal gastro-enteritis. The legs were extended and the abdomen tympanitic. The next day the distension had increased, there was no pain or vomiting, bowels not moved. Temp. 101 degs., pulse 88. August 9th, much worse, coffee ground vomit. August 10th, pulse 104, no pain, patient pallid, doubtful dulness in flanks on percussion. August 11th, pulse uncountable, pallor increased; hæmorrhage was diagnosed. Patient died before anything could be done. Post-mortem examination was made surreptitiously. The cyst was removed. The whole peritoneal cavity seemed filled with blood.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, February 17th, 1900.

PARA-APPENDICITIS.

M. BAZY, in speaking on this subject at the last meeting of the Société de Chirurgie, said that four years ago he alluded to cases of pericæcal abscesses, which seemed strange at the time to his colleagues, but since then several cases of the kind have been published. He had lately witnessed a very typical case. A young girl was brought to the hospital with a voluminous tumour in the right iliac fossa, which was considered as a case of appendicitis. The operation brought to light a mass of ganglions behind the colon, while the appendix was absolutely free from any lesion. The speaker placed a drain and the patient made a good recovery. He had operated also on a patient who three times over presented an abscess in the right iliac

region, and finally in the right hypochondriac; he suspected appendicitis, and, as a fact, the organ was diseased, and had probably provoked the abscess at a distance.

M. Juffier said that the difference between intestinal occlusion and the peritonitis of appendicitis was not sufficiently understood, and insisted on the value of the sensitiveness observed in the case of peritonitis of the recto-vesical or recto uterine cul-de-sac.

ANURIA.

At the Société Médicale, M. Renon communicated a case of absolute anuria with uræmia. A man, æt. 69, suffered from hemiplegia, voluminous heart, atheromatous arteries, &c. After complaining of pain in the lumbar region, the secretion of urine ceased, and for seven days before he died complete anuria was established but without any symptoms of uræmia. At the autopsy, the kidneys were found to be enlarged and filled with calculi. Another speaker said that it was only at the end of nine or ten days that anuria produced uræmic accidents.

PSORIASIS.

The following will be found useful in this troublesome disease:—

Salicylic acid, 3j;
Ichthyol, } 3ij;
Tar, }
Pyrogallic acid, 3iiss;
Lanoline, 3iv.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, February 17th, 1900.

SYMBLEPHARON.—TRACHOMA.

At the "Gesellschaft der Aerzte," Klein exhibited a young girl on whom he had operated for total symblepharon of the lower lid. The deformity interfered with vision as the ball of the eye was held tightly downwards at the pupillary attachment of the cornea. He separated the lid from the cornea, split it in two, and rolled each flap back, leaving the cornea to heal by granulation, uncovered. The movement of the ball is now complete with greatly improved vision.

He also brought forward a young man, æt. 22, with a trachomatous pannus, which impaired the vision as the symblepharon had done. He performed periotomy without effect, but succeeded in the Jequirity treatment, with the happy result of improved vision, though a high degree of myopic refraction still exists. He is in favour of applying the Jequirity treatment early in the disease as a preventive to the blennorrhæa inoculation.

Reus remarked that this operation for symblepharon was performed by Arlt.

EMBRYONIC DUODENAL ATRESIA.

Tandler next recorded the results of his research into the embryonic atresia in the duodenum. He found in ten embryos measuring from 10 to 20 mm. in length, the epithelium so prolific in the upper part of the small intestine as to quite obliterate its lumen. In embryos of 8 or 9 mm. in length, the canal has one layer of cells, which leaves the lumen quite distinct. When the embryo has reached 16 mm., the cells forming the core or stopper of the bowel become absorbed, leaving the bowel quite patent or normal by the time it has reached 20 mm. in length.

These results, he thought, had a practical bearing in the relative frequency of stenosis found in infancy. Out of 94 congenital cases of stenosis recorded, 33 are located in the duodenum, 55 in the jejunum and ileum, and 6 in the colon; while the proportion of length of the duodenum to the jejunum and ileum is as 5 is to 19. He thinks this persistent condition a more likely proximate cause of the stenosis than twisting of the duodenum, owing to the short mesentery, or foetal peritonitis, which has hitherto been accepted.

Fränkel said that he recently had two newborn children which died with stenosis in several places in the small intestine.

DOUBTFUL GUNSHOT WOUND.

At the Medical Club, Kienböck demonstrated a patient who seven years ago shot himself in both right and left temporal regions, but none of the cerebral symptoms occurred at the time to confirm any injury to the brain substance. About nine months ago the patient began to exhibit signs of mental weakness, which were rapidly followed by paresis on the left side with ataxia in the extremities. Suspicion fell on the gunshot wound as the original cause of this change. The Röntgen rays revealed two projectiles in the sphenoid bone in the left side of brain, one in the neighbourhood of the fissura orbitalis, the other at the base of the brain having been directed by the pterygoid process. Another bullet was found on the right side of the head, buried in the dura mater, which was evidently the cause of the nervous phenomena. The latter bullet was carefully removed but without any beneficial change to the patient, probably owing to the proximity of the motor centre, which had been injured beyond repair.

ACROMEGALIA AND DIABETES.

Schlesinger next introduced two cases with similar symptoms, though the one suffered from acromegalia, the other diabetes mellitus. From these phenomena he endeavoured to prove the connection of cause and effect with the close relationship which existed between them.

Teleky could not accept such a connection, and boldly maintained that the two diseases must have quite different causes of origin.

Sternberg admitted a close affinity in the two diseases but thought the acro-paræsthesia in Schlesinger's case was due to the climacteric period. He was quite prepared, however, to accept the theory that both of these diseases were due to some morbid change in the pancreas.

The Operating Theatres.

ST. PETER'S HOSPITAL FOR STONE, &c.

LITHOLAPAXY IN A CASE OF LARGE UNUSUALLY HARD STONE.—Mr. SWINFORD EDWARDS operated on a young and healthy-looking man, who had suffered from symptoms of stone for two years past. The patient had all the usual symptoms with the exception of hæmorrhage. Litholapaxy was performed under an anæsthetic. No. 12 A (Weiss) lithotrite was first passed, but the stone was too big to be seized by it, so a 12 B (Weiss) was introduced, but this was also not sufficiently large to grasp the stone, accordingly the meatus was divided in order to make room for one of Bigelow's large instruments; this at once grasped the stone, but the difficulty was to get and employ sufficient power wherewith to crush it. It was found impossible to do this at the first seizure

although great force was employed for several minutes after the instrument was locked to screw it up, the assistant holding the female blade with both hands, and the surgeon grasping the handle of the male blade firmly with a towel to protect the hand and employing all his force; but he was unable to produce any effect on the calculus. The stone was allowed, therefore to escape from the blades and having been seized again another attempt was made but in spite of others using their whole force it was still impossible to crush the calculus; the stone was therefore let go again, and seized afresh with the hope of getting it in a shorter diameter; this at last succeeded, as after several attempts the stone broke with a loud report after this the operation became comparatively easy, and the bladder was cleared in about 30 minutes. The *débris* showed that the stone was composed of a hard black oxalate interior coated over with a thin layer of uric acid; when dried the *débris* weighed just under 2 ozs. In spite of the rather rough manipulations necessary in the crushing of so hard a calculus hardly a drop of blood escaped from the bladder. Mr. Edwards said that if he had not succeeded on the third attempt, he had made up his mind to desist, and to do a suprapubic cystotomy.

It is satisfactory to record that a week after operation the patient is convalescent, not having had a bad symptom.

WEST LONDON HOSPITAL.

PYLOROPLASTY.—Mr. BIDWELL operated on a woman, æt. 50, who had suffered for three years from gastric ulcer, and had had several attacks of hæmatemesis, the pain being more or less persistent the whole time. The stomach was dilated and extended to about an inch below the umbilicus, no tumour could be felt in the region of the pylorus, the patient was fairly well nourished and not anæmic. The stomach contents had been examined chemically and contained excess of free hydrochloric acid. The abdomen was opened in the middle line above the umbilicus, and the stomach explored. The pylorus was found to be thickened and contracted but was not adherent to other parts; it was brought out of the wound. After an incision had been made into the stomach, the surface of the pylorus was found to admit only a No. 8 catheter, but not to be involved by any new growth. It was therefore divided horizontally with scissors, and the two angles of this incision brought together so as to convert the horizontal incision into a vertical scar. The suturing was done in two rows, the first of which was a continuous one involving all the coats of the stomach and duodenum, the second was a row of Halsted's quilled sutures passed through the peritoneal, muscular and sub-mucous coats. After the suturing was complete it was found by invaginating the stomach that the new pyloric orifice admitted the tips of three fingers. The pylorus was dropped back into the abdomen, and the abdominal wound closed with a continuous silk suture for the peritoneum and an interrupted silkworm gut for the rest of the abdominal wall. Mr. Bidwell said that this operation in non-malignant cases involves very slight risk, and has very little chance of allowing any fresh contraction of the pylorus to take place; it is, therefore, very superior to gastro-enterostomy, since in the latter operation contraction of the anastomotic opening is likely to occur after eighteen months. This untoward result happened in one of his

cases and necessitated a further operation. The other operation for a contracted pylorus, namely Loreta's, he remarked is also liable to be followed by recurrence of the stricture, although one case in which he had done this operation five years previously had suffered no further symptoms.

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“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, FEBRUARY 21, 1900.

RECONSTITUTION OF THE GENERAL MEDICAL COUNCIL.

THE deep-rooted conservatism of the medical profession is abundantly illustrated by the slow and gradual manner in which reform is brought about. In not a few instances, indeed, such as the control of hospital out-patient practice and the abolition of payments by hospital patients, it almost looks as if the day of achievement had been for ever relegated to the Ides of March. So far as the General Medical Council is concerned there is reasonable ground for hope that somewhere in the near future the constitution of that important governing body will be so altered as to bring it in touch with the interests and aspirations of the main mass of the medical profession. There is no need here to enlarge upon the shortcomings of the Council. Recent events have emphasised the conviction that after thirty-eight years of active life the Council has done little beyond raising and equalising the standards of preliminary and professional education. The funds of the Council are derived, as everyone knows, from the fees paid for voluntary registration by medical practitioners. The whole income of a body is thus provided by men who command only one-sixth of the voting power of the Council in the persons of the direct representatives. The majority of the members of Council, the remaining five-sixths, are appointed by the Crown, by the Universities, and the medical corporations.

In this way the fundamental principle that those who pay taxes should have the right of representative government is violated, and the result is that to-day the medical profession is practically governed by an autocracy. The problem now pressing for solution is how that indescribable state of affairs can best be remedied, if possible, by some well-considered and amicable scheme. For years past the Council has been urged to increase the number of Direct Representatives, and there can be no doubt that such an exercise of the power that lies in its hands would do much to conciliate adverse criticism. There is no prospect, however, of such a graceful act being performed for years to come, and the only hope appears to lie in the direction of skilfully applied outside pressure. The increase of Direct Representatives, then, should constitute what politicians would observe as one of the planks of the reformers' programme. Another proposal is that the representatives of the various Universities and medical corporations should be elected by the constituents of those bodies, instead of being nominated by irresponsible and autocratic councils as happens under present conditions. As all the world knows the control of the medical corporations has almost without exception drifted into the hands of a small knot of councillors in the election of whom ordinary graduates, licentiates and members have no voice. Twenty members of the Council are thus appointed, as against five Crown nominees and five Direct Representatives. The latter term implies on the contrary that the rest of the councillors are indirect representatives of the medical profession. As a matter of fact they are nothing of the kind, for by the nature of their nomination they go to the Council primarily to defend the interests of their own educational bodies, to the absolute exclusion of issues that are of vital interest to the main mass of the medical profession. Until the membership of the General Medical Council is vested in individuals who are in full sympathy and accord with medical men, there will be little chance of any lasting change for the better in the internal and external conditions of the profession. Clearly, if the twenty representatives of universities and corporations were elected by graduates, licentiates, members and fellows, the whole Council would be changed at one stroke from an autocratic anachronism to a representative body returned to power on a wide electoral basis. The prospect of such a consummation is sufficiently attractive to explain the enthusiasm with which it has been advocated in certain quarters. The legality of the proposed change seems beyond question, for when the Council was created in 1858 we believe we are correct in stating that there is absolutely no mention whatever made of the method in which the university and corporation representatives were to be appointed. As a practical step we should advise the formation of associations throughout the United Kingdom of medical men pledging themselves to leave no stone unturned in their endeavour to secure the right of electing the General Medical Council member of their own particular university, college, or society. The step is certain to be

strenuously opposed by the autocratic Councils, just as at the present moment they bitterly resent any attempt to limit their irresponsible government. The spectacle of the English College of Surgeons, to take one instance out of many, excluding the members from any voice in the management of the affairs of their corporation, constitutes a survival of government by a privileged class entirely out of touch with modern thought and feeling. Members of the college, who have hitherto been able to make little advance in securing their right, may do well to take up the election of a General Medical Council Representative as the chief article in their creed. Should it be found impossible to bring about this desirable reform, after a reasonable period of trial it will be well to approach Parliament with a view of securing legislation upon the point. That part of the agitation might be left to the British Medical Association, which has hitherto done remarkably little in the direction of protecting and advancing the consolidated interests of the profession. Meanwhile we commend the reconstitution of the Council by way of a universal enfranchisement of medical men as offering a prospect of the most peaceable and effectual revolution that could be desired by members of a noble and humane but, alas, unbusinesslike and disorganised, profession.

THE STERILISATION OF MILK.

It is generally agreed that cow's milk in its natural state may be the means of dissemination of various diseases, and latterly this subject has claimed much attention owing to the connection between the dissemination of tuberculosis and milk supplied by tuberculous cows. The importance of this aspect of the question cannot be too highly insisted upon, and especially for the reason that such a contaminated milk supply may do an incalculable amount of harm without exciting suspicion. In the days before the tuberculin test was employed, no doubt, tuberculous disease in the form mainly of *tabes mesenterica* was extensively conveyed to infants and young children. But even now-a-days this test cannot be absolutely relied on, and, therefore, the need is very great for the general adoption of some means by which milk is rendered incapable of transmitting disease. The method of sterilisation known as the Pasteurisation of milk is that which is deemed to be the least open to objection, but the drawback so far has been the difficulty of applying the process to milk in bulk. Small quantities of milk can be readily prepared in this manner, and many children in the present day are brought up upon sterilised milk. But in the abstract, of course, when milk is known in its natural state to be a frequent medium of the communication of disease, it can scarcely be disputed that every public milk supply in the kingdom should be subjected to some sterilising process. Indeed, the time seems to have come when further legal measures beyond those already in existence should be resorted to in order to ensure the wholesomeness of milk for public consumption. At present the law protects

the consumer against the adulteration of milk with water, the abstraction of cream, or its artificial preservation by means of boracic acid. But in view of the harm resulting from the contamination of milk with pathogenic micro-organisms, it becomes a serious matter whether the State should not compel every purveyor of milk to issue it in a sterilised form. If this were the case much diminution would result in all probability in the prevalence of those diseases with the dissemination of which milk is known to be largely concerned. Moreover, after all, the absence of bacterial contamination of milk is a much more important matter to the well-being of the community than its adulteration with water or boracic acid. For while the worst that can be said of these forms of adulteration is that they destroy, more or less, the nutritive qualities of the milk, on the other hand the pathogenic infection of milk frequently leads to the most serious outbreaks of disease. Practically, however, under present circumstances, the law affords no protection to the consumer so far as the latter contamination is concerned. All that can be done in the matter can only be done after harm has been caused. Take, for example, the instance of an epidemic of diphtheria which has been traced to an infected milk supply. As soon as the sanitary authorities have discovered the source of the disease measures are taken to prohibit the sale of the milk whence the infection has originated. In other words, this is clearly a case of locking the stable-door after the horse has escaped. Whereas, it is evident that in such a case, had the purveyor of the milk been compelled by law to sterilise it, in all probability, despite the fact that he might have had a case of diphtheria upon his premises, his milk supply would have remained free from infection. We understand in this connection that machinery has now been introduced making it a comparatively easy matter to sterilise milk in bulk, and an article appeared in the *Times* of last week stating that, in Bath, a milk company were supplying all their customers with sterilised, or pasteurised milk. The matter to which we here draw attention, we believe, is one which demands serious consideration in the interests of the public health; no one can dispute that prevention is better than cure, and as a preventive method against the dissemination of disease, the compulsory sterilisation of the public milk supplies would probably be attended with much benefit to the health of the community.

THE ABLE-BODIED WORKHOUSE INMATE.

THE expression of opinion which we find in the reports of recent proceedings of Irish Boards of Guardians gives us cause for the hope that the comfortable reign of the able-bodied pauper under Guardians administration is coming to an end. The Belfast Board has the honour to lead the crusade which, we trust, will tend to the extinction of the able-bodied pauper in its own workhouse, for we observe that, not trusting the stereotyped reports of officers,

it caused a barrack-yard inspection of them to be held so that each guardian could come and see for himself. Eight hundred men, whom the medical officer pronounced to be in perfect health, were lined up for inspection. Of these, six hundred were apparently over sixty years of age, and, therefore, could scarcely be turned out of the house to work in competition with younger labour, but were perfectly capable of earning their crust by some light work, such as fire-wood chopping or mat making within the House. In addition to these six hundred, 170 comparatively young men, every one of whom is as capable of bread-winning as any labourer in Ulster were presented, of whom seventy-two were supposed to be giving some value for their maintenance by small work in the House. One hundred remain who do not make any pretence of doing anything from year's end to year's end but walk about, eat, drink, and smoke pipes at the expense of the ratepayers. So much for the men. The condition of affairs as regards the women is much worse in Belfast; 42 of them are "separation" women, who amused themselves at the inspection by gibing at the Guardians and making criticisms on their personality. 79 were classed as nursery women, every one of whom had one or more children in the house. It may safely be predicted, as regards these classes of women in every workhouse in Ireland, that a considerable proportion are prostitutes *in esse* or *in posse*, and that a similar proportion of their children supported by the taxpayers are illegitimate. Belfast is but one out of 159 workhouses in Ireland in which the drones of the industrial hive are fattened by the half-starved working bees. During the greater part of the year able-bodied labour is at a premium, and wages are readily forthcoming which would keep the labourer (outside the public house) in comparative luxury. Probably neither the public nor the ratepayers appreciate the extent of this abuse, and it will be no harm to enlighten them. According to the Report of the Local Government Board for Ireland for the year 1899, able-bodied paupers to the number of 292,712 occupied the Irish workhouses. These, of course, included the floating population of tramps and people who were driven to seek shelter until they got work, but it may be taken from these figures that, on an average of every week in the year, an army of 5,629 able-bodied paupers occupy the Irish workhouses. The average cost of maintenance of each is about 3s. 8d. per week, which amounts to £1,031 per week or £53,612. We do not hesitate to say that the greater part of this large sum could be saved by a little watchfulness on the part of the Local Government Board and the guardians, and, perhaps, by some slight amendments in the existing Local Government law. The old inmates could be made self-supporting by giving them a little light work in or out of the House, the younger men and women could be induced to leave the House and earn their own bread by forcing them to do as much and as hard work in the House as would keep them outside, and most of the women

would take their children with them when leaving. How long are the ratepayers going to stand being sponged on by an army of lazy louts, male and female? Here is a chance for the glorious reformers who, under the new Local Government Act, have taken up the administration of Irish workhouses. Let them, instead of squabbling over a few shillings wrung from the sweat of the dispensary doctor, give their minds to the hundreds and thousands of pounds wasted in demoralising a small army of the Irish working classes.

Notes on Current Topics.

The Diet of the Poor.

AN investigation of considerable magnitude and importance is proposed to be carried out in Edinburgh by the Superintendent of the Royal College of Physicians' Research Laboratory, assisted by Dr. J. C. Dunlop and a number of other co-workers, into the nature and metabolic value of the foods ordinarily obtained, and usually consumed by the poorer classes, especially by the very poor. Last week the Superintendent, Dr. Noel Paton, addressed a letter to the Town Council, suggesting that the Council might take an official interest in the matter, and support this interest pecuniarily by voting £50 to allow it to be gone on with, as it was a subject of deep economic and humanitarian importance. The principal objects aimed at are the obtaining of data as to the sufficiency or insufficiency of the dietaries of the very poor for physiological requirements, as to the foods which they might secure at the least possible cost and, at the same time, of the highest nutritive value *per unit* spent on them, and as to the actual nature of the food-stuffs consumed, and when and how they are taken. The research will be conducted on the strictest scientific lines. The Town Council gave the subject their general benediction, and sent it to their Public Health Committee for consideration and report. The fact that the projected research is to be conducted under the most rigid rules of science, and supervised by experts already experienced in metabolic and dictative investigations, gives promise of results which must certainly be theoretically of value both from the side of political economy and from the view of the physiologist; whether they will suffice to convince that class which are most practically concerned with them is another and much more doubtful question. Before now the nutritive values of almost all articles of food have been theoretically determined, and their money value calculated from time to time in relation to current prices prevailing. The points which would offer most return, we should say, are those connected with modes of preparation of food and changes in utilisation, and those bearing upon the use or abuse of alcohol on domestic metabolism. The members of the class proposed to be placed under observation, who are most likely to agree to and fulfil the necessary conditions, will naturally belong to its well-conducted section,

the honourable though poor. An investigation into the actual yield in nourishment of the foods used by more disreputable or thoughtless families, if practicable, would be of interest as indicative of what men will be content to live on, although able to afford a better diet, so as to be able to spend a greater or less proportion of their earnings upon drink, tobacco, or amusement.

Sensory Acuity of the Female Genitalia.

A QUESTION has on various occasions been raised whether the tactile sense of a woman in respect of operations on the genitalia enables her to assert that an instrument has actually been passed into the uterus. In a recent number of the *Archiv für Gynäkologie* Dr. Calman gives the outcome of a series of observations which he has made on this point. He expresses the opinion that the sense of localisation is very imperfectly developed in the female genito-urinary system, the local differentiation between the urethra, bladder, and vagina being very uncertain. The sense of touch is markedly deficient, and a woman is unable to form any opinion as to the length of an object introduced, and although the thickness of the object is to some extent perceived, nothing approximating a correct estimate of its diameter can be made. There is, moreover, great obscurity as to the form and other characters of the object introduced, and even the number of objects is rarely gauged accurately. There seems to be no sense of touch in the portio vaginalis and in the uterus proper. This sense is comparatively well developed in and around the urethra, but in the vagina it is very feeble. The sense of temperature is also fairly well developed in the urethra, but much less so in the vagina, especially in regard to higher degrees of heat, while it is totally absent in the uterus. Pain is quickly perceived in the urethra, and in the cervix it is dull, but in the uterus itself painful sensations are often acute. Gynecologists are familiar with the fact that the uterus can be manipulated and even incised without causing pain, but movements imparted to the uterus as a whole are perceptible to the patient, not so much by reason of its inherent sensitiveness, as of that of its anatomical relations. So far as the vagina is concerned sensation appears to be limited to the vulva.

Company Pharmacy and Joint Stock Doctoring.

As the President of the Board of Trade, Mr. Ritchie, has introduced into the Commons the two Bills which passed the Lords last session promoted by the Lord Chancellor, it seems obvious that the Government is determined to pass them if the exigencies of Parliamentary work permit. These Bills are designated to amend the Companies' Acts, and, in the case of pharmacy trading, it is provided that no company or syndicate shall dispense unless under the supervision of a fully-qualified pharmacist. This provision, when supported by the Lord Chancellor in the Upper House last year by no means satisfied the chemists, because it allowed co-operative

companies and such like to carry on business freely, as dispensers by the agency of any number of unqualified assistants as long as one qualified man is in control and supervision. We sympathise with their protest, but we cannot see how the proposed new law can be resisted on public grounds. The second Bill, or portion of a Bill refers to joint stock doctoring and absolutely forbids any company or syndicate to carry on business as physicians, surgeons, or midwives, unless each and everyone of the members is a duly registered practitioner. Such a provision is essentially in conformity with the existing law. Every individual, whether member of a company or not, can practise as widely as he pleases, but always on his own responsibility, and subject to the disabilities which the Medical Acts impose upon unqualified practitioners, and the ostensible supervision of his practice by a qualified doctor cannot relieve him of these. If such practitioner attempts to shield the unqualified man by signing death certificates, or performing other function which is reserved for the legitimate profession, he forthwith brings himself within reach of the law, and can be debarred by the Medical Council. It is thus obvious that the cases of the chemist and the doctor are not on all fours, and the chemist should not be jealous if Government makes a distinction which the existing law has already made.

The London Asylums Board and the War.

PATRIOTISM is an admirable quality whether displayed by the individual or by public bodies. At the same time, like all emotional conditions, it should not be allowed to run counter to the dictates of sober judgment. Miss Atkins, late matron of the Park Hospital, has furnished an object lesson to the philosophic citizen by sending in an application for leave of absence to the Metropolitan Asylums Board, in order that she might join a hospital in South Africa. A stormy discussion followed, but eventually the application was refused on the ground that the first duty of the Board was to deal with their own sick at home. The resignation of Miss Atkins was then handed in and accepted by a large majority. Her action can hardly be upheld, as there is no dearth of candidates for nursing posts at the front, and it was open to Miss Atkins to resign her post before going out, without asking the ratepayers to pay for her services during an uncertain period of absence. The case does not fall within lines similar to those that regulate the volunteering of soldiers.

A Mistress's Responsibility.

It is to be feared that the law in respect of the use of public vehicles for the conveyance of persons suffering from infectious diseases is not as generally known and acted upon as, in the interests of public health, one could desire. Only last week a lady living in the suburbs of London was summoned for having caused her servant, who was suffering from

diphtheria, to be taken to the hospital in a cab, and though she escaped on the technical ground that she could not be considered to be in charge of her servant, it was abundantly evident that in directing the young woman to be thus transported the lady was acting in blissful unconsciousness of the fact that in so doing she was rendering herself liable to prosecution. What is even more remarkable is that one medical man who saw the patient actually suggested that she should be taken to the hospital on the top of a tramcar, a course which would possibly prove more detrimental to the patient than to the other travellers. It would be well for sanitary authorities to take steps from time to time to bring the principal laws relating to the management of patients suffering from infectious diseases to the notice of those whom it may concern, for while a small number of persons may sin from indifference or sheer wilfulness the majority undoubtedly err from ignorance or thoughtlessness. Especially does it behove medical practitioners to make it clear to those in charge of such patients that by adopting any other mode of conveyance than an ambulance, unless they are prepared to pay for the subsequent disinfection of the vehicle, they will render themselves liable to the penalty in that case made and provided. There is the less excuse for neglect, seeing that ambulances are specially provided for the purpose, and are available at any hour of night and day.

Fees for Urgency Police Calls.

WE are pleased to be able to state, on the strength of a letter which we publish elsewhere, that the Police authorities of the City of Bradford have revised the scale of remuneration allocated to practitioners who place their services at the disposal of the Police. The original fees were half-a-crown for a day visit, and five shillings (!) for a night call—sums which gives a poor idea of the value attached to such services. Under the revised scale the fees will be five and ten shillings respectively. This highly desirable modification is the outcome of an interview between a delegation of members of the Bradford, and the West Riding and Bradford, Medico-Ethical Societies, and the committee of the City Council, and it is gratifying to find that a satisfactory *modus vivendi* was arrived at.

Alcohol in Carbolic Acid Poisoning.

CARBOLIC acid, even in comparatively small doses, is a very violent poison, acting as it does, locally in virtue of its caustic effects on the membranes with which it comes into contact, and on the organism at large as a powerful depressant. According to an article which appeared in a recent number of Merck's "Archives," the best treatment for carbolic acid poisoning is the administration of several ounces of whisky, brandy, or other spirit, suitably diluted. This combats at the same time the irritating local action of the acid and its intensely depressing influence on the nerve centres. The next step is to wash out the stomach through a soft rubber tube, syphoning in the usual way, and this process may

advantageously be repeated several times at short intervals. We shall then have reached a stage at which the exhibition of sodium sulphate is indicated, and a drachm or so of the salt dissolved in a wine-glassful of water should be swallowed. Statistics of the results of this treatment tend to show that it is attended by a large measure of success, and in view of the extreme fatality of this method of poisoning and its exceeding frequency we commend it to the notice of our readers.

What is Milk?

THE first step towards the efficient control of the purity or quality of any article of food clearly lies in establishing a standard. In the case of milk, no satisfactory "normal" has yet been fixed, and the decision has consequently been left roughly to the opinion of various more or less eminent chemists. The obvious injustice of such an indeterminate state of affairs was shown, if we may accept the evidence for the defence, in a recent trial for milk adulteration. The defence stated that a sample of milk taken direct from the cow was sent for analysis to Somerset House, and there certified to be adulterated with 10 per cent. of added water. Whether the assertion, presumably supported on oath, influenced the verdict or not is not clear from the short report of the proceedings given in the daily newspapers, but the suggestiveness of the matter is great. Here we have a Government Office, always supposing the defendant's evidence to be true, stultifying its own analysis and authority. The fact of the matter is that the milk of a cow may vary within wide limits according to the food, the state of health and other circumstances of environment affecting the animal. For a long time past dissatisfaction has been expressed in the metropolis with the methods of the Somerset House Analytical Department, and small wonder if they possess no scientifically established standard for so important an article of food as cow's milk. An enormous number of interests are involved in the milk trade as concerns farmer, dairyman, and consumer. A great many prosecutions take place for adulteration of this food-stuff, and were it once proved that the official analysis of milk taken straight from the cow was untrustworthy the possibility of successful defence against prosecution would be greatly increased. The importance of the question has been recognised in Parliament by the appointment of the Milk and Cream Standards Committee, which is about to sit. It has been appointed by the President of the Board of Agriculture to inquire as to what regulations may advantageously be made for determining what deficiency in any of the normal constituents of milk and cream, or what addition of extraneous matter or proportion of water in any sample of milk (including condensed milk) or cream, shall raise a presumption that the milk or cream is not genuine. It would be reassuring if the Board were to extend its inquiries into the organisation of the Analytical Department at Somerset House. Meanwhile, it is somewhat difficult to answer the question, "What is milk?"

Emaciation in Hysteria.

EMACIATION is always a serious condition, and when marked and progressive, is generally indicative of some organic disease, which is not unlikely to prove fatal. Its connection, however, with hysteria has been noted by Osler. He had a fatal case under his care in which the emaciation was so extreme that the patient, a girl, weighed only forty-nine pounds, but no post-mortem lesions were found. Another case has been recorded by Beath, of Winnipeg. The patient was a girl, æt. 18, who when she came under the author's care, weighed with heavy boots, clothing, hat, and shawl forty-four pounds. She had never menstruated, and her organs were in every respect normal. The curious point was, however, that despite the extreme emaciation which was present, she was able not only to come ten miles in a lumber wagon sitting upon a backless seat, but to walk up a flight of stairs immediately afterwards to see the doctor. Her appearance was that of a jointed skeleton covered over with a tightly-drawn skin. There was no question as to the hysterical nature of the case. The treatment adopted was partial segregation for four weeks and Weir-Mitchell treatment, under which she gained seven pounds. Ultimate recovery followed, and the patient is now plump, active, and enjoying life. The case had been diagnosed as one of "consumption," and the parents had been led to believe that recovery was hopeless. A point of interest, however, in these cases is, to what is the emaciation due? This is a difficult matter to determine, and no satisfactory explanation has so far been forthcoming. Anæmia, of course, is present, but defective assimilation, even the food taken, would presumably be mainly concerned in bringing about the wasting.

Survival of Functions after Death.

DR. LABORDE has found by direct experiment that the functions of the tissues and organic elements of the body do not at once fall into abeyance with the apparent death of the subject, that is to say, with the cessation of what we are accustomed to describe as the vital functions. The respiratory reflex caused by rhythmical traction on the tongue, for instance, can be obtained for a variable period after the pulse and breathing have ceased, and it is to this ephemeral prolongation of functional activity that Dr. Laborde attributes the possibility of bringing back to life persons who have ceased to live some time before.

Thyroid Extract in Non-union of Fractures.

IN certain cases of non-union of fractures the internal administration of thyroid extract has determined consolidation, instances of which were recently brought before the French Society of Surgery by Dr. Potherat. Inasmuch, however, as non union of fractured bones is dependent upon a variety of physical and mechanical causes it would obviously be idle to expect the same treatment to effect an equally good result in all. In any case the suggestion adds another method to our *repertoire* in dealing with a very troublesome class of cases.

The Prince of Wales and Sir William MacCormac.

THE Prince of Wales at the meeting of the General Council of his Hospital Fund last week, paid a graceful tribute to the patriotism of Sir William MacCormac, who is now at the front. "I may say," said His Royal Highness, "that one of the members of our Council, the President of the Royal College of Surgeons, Sir William MacCormac, is, as you are all aware, now at the seat of war. At his time of life the performance of the arduous duties that this necessitates, reflects, I think, great credit on him, and gives the utmost satisfaction to all who know him." In these graceful words the Prince refers to a point which has already caused not a little comment favourable to the action of the President of the English College of Surgeons. He has reached a time of life when leisure and repose may rightly be claimed after many years of professional work; but despite this, Sir William elects to undertake the hardships and risks of a campaign, and discharge duties which would be arduous even for those who have youth on their side.

Another County Court Judge on Medical Fees.

WE are glad to see that a London County Court Judge, his Honour Judge Stonor, of the Marylebone County Court, has had an opportunity of amending in some measure the ignorance or prejudice respecting medical fees displayed recently by Judge French. He found that the charge per visit, with medicine, to a publican, of five shillings, was not excessive, and the plaintiff, practising in Bayswater, won his case. The plaintiff is to be congratulated upon the fact that his case was heard by Judge Stonor and not by Judge French, for judging from the idea prevalent in the mind of the latter as to the value of a medical man's services, there is no saying what the result would have been. This fact has become so notorious in the district of the Bow County Court, that some practitioners rather than expose themselves to the decision of the presiding legal luminary, prefer to settle their cases as best they can without an appeal to his judgment.

Achromatopsia for Blue in Bright's Disease.

BLINDNESS in respect of blue rays is a symptom which is common to many forms of retinitis, but it appears to be specially associated with chronic interstitial renal disease. Attention was called to this fact in 1897 by Drs. König and R. Simon, and since that time further observation has confirmed their results. Quite recently Dr. Gerhardt reported three cases in which this phenomenon was present in patients suffering from granular kidney, one of them being of plumbic origin. This point merits more careful investigation, since it may possibly furnish us with another diagnostic element in chronic renal affections. In all the cases blue appeared to the patients as black, the disability in some instances disappearing with an improvement in the functional condition.

War, Commerce, and Physic.

THE present campaign in South Africa is an altogether novel departure in that it is being carried on to some extent by voluntary subscription. Donations in hard cash, and in articles such as woollen garments and chest protectors, must always be welcome, but there is a comic element, the only one as things go, in the avidity with which manufacturers of out-of-the-way medical and pharmaceutical appliances and preparations have availed themselves of the opportunity to air their patriotism, and secure a gratuitous advertisement for their pet products. One would think that a notice had been displayed at the War Office to the effect that "rubbish may be shot here." The inventor of a patent truss sends an assortment of his goods to the front, a soap manufacturer, fancying no doubt that the Government would probably overlook such a detail, hastens to send a few tons of his unquestionably useful product, and the vendors of pills, liniments, and cough tablets offer munificent supplies. All the antiseptic and healing ointments yet devised are forced upon the jaded attention of the authorities, and even pocket-handkerchiefs are not forgotten, embellished, as the case may be, with patriotic pictures or scripture texts. What the authorities in South Africa will do with this *olla podrida* it is difficult to say, but we trust our soldiers will not be persuaded or cajoled into experimenting on themselves with any of the internal or external remedies so generously placed at their disposal by enthusiastic but shrewd donors. The probability is that very little of this miscellaneous assortment will ever reach the troops. The lots will be warehoused for a time in some out-of-the-way corner here, or will be dumped down on the quays at Durban and left to moulder.

Salvation Shelter and its Sick.

THE danger to the public arising from the methods of the Salvation Army Shelter authorities has been demonstrated by the litigation that for the last seven or eight years has dragged its slow length through the law courts. Fortunately, all that is now ended by the final decision that places the shelters within the wholesome provisions of the Common Lodging Houses Acts. It is no small matter of wonder how persons professing high religious ideals should resist to the utmost of their power the attempt to protect the health and the lives of their fellow creatures. Philanthropy of this emotional kind, however, especially when it labours under the fatal shadow of semi-commercialism, is apt to develop strange inconsistencies. That tendency is further illustrated by the treatment of a dying inmate of the Holborn Shelter, according to statements made last week before a London coroner. It appears that the unfortunate man had been staying on and off in the Shelter for a fortnight, and was found very ill one morning by a room orderly. He was got out of bed and dressed by a Shelter official, who then took him off to the Relieving Officer. The latter had him at once carried in an ambulance to the infirmary, where he died a few hours after admission. The fact of a medical man not having been called in to see deceased

was strongly commented on by the coroner, who advised the officials present connected with the Shelter in future not to try and save the Salvation Army's money in that way. The appointment of a regular visiting medical officer would do something towards restoring the rudely shaken confidence of the public in these Shelters. What with vermin, the spread of infectious disease, bad sanitary environment, and absence of medical attention to sick inmates, the need of stringent control of night refuges is more than apparent.

War Service as the Student's Equivalent for Hospital Attendance.

WE note that it has been referred by the Council of the Royal College of Surgeons of England to the Committee of Management of the London Conjoint Examinations, to consider and to report to the two Colleges on the recognition of the services rendered by medical students at the seat of war as a part of the hospital curriculum. It is quite possible that the work which a student may see at the seat of war will be a fair equivalent for a period of hospital walking in London, but the recent spreading of the net for grammar school boys and other small fry inspires us with a suspicion that this is another baiting of the crib for the unfledged birdlings of trans-London teaching centres.

DR. DAVIDSON, who keeps a drug shop at Shettleston, Glasgow, was charged last week with having sold laudanum *per* his unregistered assistant in contravention of the Pharmacy Acts. The charge was preferred by the Pharmaceutical Society, and the defendant fined £3, with two guineas costs.

It is not at present intended to accept for war service members of the Volunteer Medical Staff Corps who do not fulfil the conditions laid down in the Special Army Order of the 5th inst., but should the numbers obtained fall short of those anticipated the subject will be further considered.

PERSONAL.

DR. LANGFORD SYMES is also a candidate for the vacant post of Registrar-General for Ireland.

THE PRINCE OF WALES, representing Her Majesty, has promised to lay the foundation of the new buildings of the Newcastle Royal Infirmary on or about June 15th.

SIR PHILIP SMYLY has been re-elected by the Royal College of Surgeons in Ireland as the representative of the College on the General Medical Council for the ensuing year.

WE regret to learn that Major Walter Riddle, M.D., Royal Army Medical Corps, was murdered by natives in Burmah while engaged in his duties as medical officer in charge of our frontier forces in that country.

SURGEON-GENERAL WILLIAM TAYLOR, C.B., Principal Medical Officer on the staff of the Commander-in-Chief in India, has been awarded a good service pension of

£100 a year as the reward of 35 years' active service in the army.

A LODGMENT for lady medicals has been effected in Guernsey by Mrs. Mary Bishop, L.R.C.S. Edin., who, ten days since, was admitted by the Royal Court of the island to practice her profession there. She is the first lady doctor who has obtained such permission, but there is another lady practitioner who, being a native, had no necessity to apply.

Dr. HOPE, principal Medical Officer of Health for the City and Port of Liverpool, presented on behalf of the subscribers last week, a massive silver inkstand to Dr. Ed. P. Manley, the assistant Health Officer, in token of appreciation of his services, prior to his departure for London, where he has received an appointment under the Local Government Board.

Dr. J. PURVES STEWART, M.A., M.D., M.R.C.P., assistant physician to the Westminster Hospital, has been appointed Physician to the Imperial Yeomanry Hospital, and, in company with Mr. Charles Stonham and a staff of dressers and clinical clerks, will shortly proceed to the front. Dr. Purves Stewart is an Edinburgh man, and has only been on the staff of the Westminster Hospital for about a year, but his temporary loss will be severely felt, as he is a good teacher and most enthusiastic in his work.

No appointment to the position vacated by the death of Dr. Grimshaw has yet been made, nor are there, as far as we know, any new developments. It is suggested and currently believed, that the functions of the office will be divided, and that, whosoever may be the Registrar-General for Ireland, there will also be a Medical Superintendent of Statistics. If such appointment be made a re-arrangement of salaries will probably be necessary, as the Treasury will not be likely to tolerate any additional outlay on the Department.

MR. VICTOR HORSLEY AND THE GENERAL MEDICAL COUNCIL.

We are asked by the Hon. Secretary of the Bradford and West Riding Medical Union to publish the following resolution, which he informs us was carried *nem. con.* at the general meeting held on the 15th inst.:-

"The members of the Bradford and West Riding Medical Union beg to offer their hearty congratulations to Prof. Victor Horsley, F.R.S., one of the direct representatives of the medical profession on the General Medical Council, on the success with which he has struggled to defend the interests of medical practitioners against the continued neglect shown by the representatives of corporations on the General Medical Council, and hope that the medical profession may long continue to have the advantage of being represented on the Council by a gentleman so distinguished alike by scientific attainments and by remarkable energy and skill in pushing the work of reform, which is so much needed."

THE PROFESSORSHIP OF SURGERY IN QUEEN'S COLLEGE, CORK.

THE position vacated by the recent death of Dr. Stephen O'Sullivan has been filled by the appointment thereto of Dr. C. Yelverton Pearson, surgeon to the North Charitable Infirmary and to the Cork Hospital

for Women and Children. As a student he took a scholarship and gold medal in the College, and served honourably after graduation as a Demonstrator of Anatomy and Professor of Materia Medica in it. He is a Fellow of the London College of Surgeons, and has twice occupied the presidential chair of the Cork Medical and Surgical Association, his inaugural address on abdominal surgery having been published in the MEDICAL PRESS in 1897. He has also been a frequent contributor to the proceedings of the Royal Academy of Medicine of which he is a Fellow.

THE SURGEONCY OF THE QUEEN'S COUNTY INFIRMARY.

THE hearing of the law arguments as to the validity of the recent election of Dr. Blaney to be Surgeon in place of Dr. William Jacob, whom the new Board of Governors suppose that they have dismissed, was listed for the sitting of the High Court in Dublin for yesterday (Tuesday.) The question at issue is whether these Governors have power to dismiss a surgeon, having regard to the new Local Government law and the special circumstances of the case. We understand that a heavy bar has been retained. For the Governors, Mr. T. M. Healy, Q.C., M.P., Mr. Dudley White, and Mr. Falkiner, Q.C. For Dr. Blaney, The MacDermot, Q.C.; and for Dr. Jacob, Mr. J. M. Campbell, Q.C., M.P., Mr. Ronan, and Mr. Brunskill.

Scotland.

[FROM OUR OWN CORRESPONDENT.]

WAR HOSPITALS FROM SCOTLAND.—Scotland has recently done her duty nobly for the Empire in many ways, in flesh and blood and in kind. She still further proposes to contribute to the Imperial resources by sending out two fully-equipped base hospitals to South Africa, a National Red Cross Hospital, and another almost entirely raised in her metropolis, Edinburgh. The first is to be representative of all Scotland, the second of Edinburgh alone. Notwithstanding the large sums already given by the citizens of Edinburgh to the various funds in connection with the war, only a few days after the appeal for this new scheme appeared a total of £13 073 had been subscribed out of the £20,000 asked for. The Committee in charge of the scheme include:—The Lord Provost, Earl of Hopetown, the Lord President of the Court of Session, the Lord Justice Clerk, General Chapman, the Provost of Leith, the Master of the Merchant Company of Edinburgh, Sir William Turner, M.B., P.M.C., Professor Chine, Dr. Joseph Bell, and Colonel Warburton, R.A.M.C. The National Hospital has its origin in the St. Andrews Ambulance Association, now recognised as an official branch of the Red Cross Association of Great Britain. The Marquis of Breadalbane acting as President, and Dr. P. A. Toving as the Chairman of the Edinburgh branch.

THE CHAIR OF PRACTICE OF PHYSIC IN THE UNIVERSITY OF EDINBURGH.—The supporters of the candidatures of Drs. Wythie, Bramwell and Gibson for this Chair have severally issued testimonials for signature to members of the profession in Edinburgh, and those elsewhere connected with the University, on behalf of each applicant. Drs. Alexander James, and Robert A. Fleming have also, we understand, sent in applications.

INFLUENZA is still rife in Edinburgh, and many cases of influenza pneumonia have been, and still are, met with.

A LABOURER, æt. 32, of Walton-on-Thames, died of tetanus at St. Thomas's Hospital last week, as the result of a wound of the thumb sustained while snow-balling on the 3rd inst.

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

MEDICAL MEN AND URGENCY CALLS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The Watch Committee of Bradford have inaugurated a very striking and useful era for general practitioners. The area of this city has been recently much enlarged, and the police street accident work much increased under the Council's jurisdiction. To meet this the town clerk sent notices to all medical men in the city asking them to attend, on request of the police, who are armed with proper forms, any accident nearest to their homes, at the following scale of charges:—

	s.	d.
Day-time, 9 a.m.—9 p.m.	5	0
Each call in night-time, 9 p.m.—9 a.m. ...	10	0
Petty Sessions Court at Town Hall	10	6

The compliment is highly appreciated by the doctors here (showing a recognition of the individual rights of a general practitioner), and it is hoped that guardians and other representatives may act in a similar public spirited way. The first terms offered by the Watch Committee were about half those now offered; this result of doubled fees was brought about by the joint effort of the two Ethical Societies here acting in concert. These changes leave the police surgeon unaffected, save for an increase in his salary and fees.

I am, Sir, yours truly,
PRECY G. LODGE.

THE DISPENSING OF MINUTE DOSES OF ALKALOIDS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The erroneous impression conveyed in recent issues of THE MEDICAL PRESS AND CIRCULAR that retail pharmaceutical chemists are incapable of dispensing minute doses of potent drugs having been brought under the notice of the Council at their last meeting, I have to say that, on behalf of the licentiates of the Pharmaceutical Society of Ireland, my Council protest against such statements, and they have directed me to hand you the accompanying report of their discussion on same, and to request you to publish it in your next issue.

I am, Sir, yours faithfully.

ARTHUR T. FERRALL, Registrar.

Dublin, February 17th, 1900.

[We trust it will not be considered disrespectful to say that, as we have already twice pointed out that we never made the statement herein attributed to us, we think it unnecessary to repeat the disclaimer now. We submit that the Council of the Pharmaceutical Society might advantageously have—by inspection of our columns—acquainted itself with what we did say before sending us this communication.—ED.]

THE DEATH-RATE OF LIVERPOOL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I shall esteem it a favour if you will kindly give me your reasons for making the following statement in reference to the recent high rate of mortality in Liverpool, viz.:—"Although an influenza epidemic had claimed many victims, the returns nevertheless indicated that only one-fifth of the increase could be attributed to this disease. It has therefore been pertinently asked, if only this small proportion of the increase could be assigned to influenza, how was the remaining percentage of the augmented death-rate to be accounted for? No satisfactory reply to this query has, so far, been forthcoming. . . . It has been said that the city is the resort of the residuum of the working classes, who take shelter within its confines when they cannot obtain work elsewhere. But it does not appear that the death-

rate is especially high among the classes in question, and therefore this explanation does not seem to us to be adequate, at all events so far as Liverpool is concerned."

I may state for your guidance that since the sudden rise in the death-rate in the third week of December, influenza has been very prevalent, and although the number of deaths attributed solely to it have not exceeded twenty-four in any one week, yet the associated pneumonia and diseases of the respiratory system have been very great; moreover, the deaths in workhouses and hospitals since the period in question have furnished no less than 26.5 per cent. of the total.

You may perhaps have noticed that Brighton, which has but a fraction of labouring population, has had during the recent prevalence of influenza a far higher death-rate than has been recorded in Liverpool within my memory.

I am, Sir yours truly,

E. W. HOPE,
Medical Officer of Health.

Public Health Department, Liverpool,
February 10th, 1900.

[While we have pleasure in publishing Dr. Hope's letter, it is not altogether easy to understand the drift of his inquiry. It is not clear to what particular "statement" he refers in asking for "reasons." The general aim of our paragraph was to draw attention to a fallacy in influenza returns, which is borne out by Dr. Hope's figures. Then, again, the theory as to the possibility of a labouring population causing an increase of influenza mortality was dismissed in our remarks as unsatisfactory. We cordially agree with Dr. Hope's implied belief that the deaths from the disease in question are mainly due to secondary causes. A formal communication upon this most important subject from so able a statistician as Dr. Hope would be welcome to our readers. The abnormally high death-rate of Liverpool is generally attributed in part to poverty and overcrowding and the environment incident to a large labouring population.—ED. M. P. and C.]

CONTAGIOUS DISEASES ACTS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am sure your readers will be interested to see a *précis* of M. Fournier's views respecting the prophylaxis of syphilis. M. le Dr. Alfred Fournier, Professeur à la Faculté de Médecine de Paris, Ricord's successor and Physician to l'Hôpital St. Louis, has recently (November, 1899, shortly after the Brussels Congress, which he attended) formulated his views as to the prophylaxis of syphilis in a paper which he has presented to the Académie de Médecine de Paris. (a) He says the best of all methods of preventing syphilis is by the inculcation of moral and religious principles, in other words, as M. Ricord has remarked, "the only way" to escape syphilis is to avoid the risk of catching it; syphilis does not fall down from heaven, and no man need inoculate himself unless he deliberately chooses." As to the actual system of the Police des Mœurs in Paris—a system which we are asked to copy in England—M. Fournier, and no higher authority can be quoted, declares that it is "insuffisante, impuissante et caduque" insufficient, powerless, and rotten to the core. This is, he says, owing to the fact, on which I have laid stress, that the police can only bring under control a few women (two or three thousand), while six, eight, and ten times as many escape control and spread syphilis among the population of Paris; the police, he says, do the little they can, and we must thank them, but it is impossible for them to check the spread of venereal disease. "Elle est impuissante à indiquer le flot débordant des contaminations vénériennes."

M. Fournier adds: little as the police have done, they

will do still less in the future, and for the following reasons:—1. Because the licenced brothels are steadily and inevitably diminishing in number; women cannot, much as the police try, be driven into them and kept there prisoners. 2. Because of the immense increase of clandestine prostitution which is constantly increasing. 3. Because of the strong public feeling which is opposed to the arbitrary action of the police (upwards of twenty thousand women are arrested every year in Paris, outside of all legal forms, and may be detained from a few weeks to a year); and 4, because of the demonstrated powerlessness of the system to prevent syphilis or diminish venereal diseases, in proof of which M. Fournier says we have syphilis with us now as we have always had it. "A-t-elle par exemple jamais diminué de fréquence depuis une quarantaine d'années que j'en ai fait l'objet de mes études spéciales? Impossible à moi de le croire d'après ce que j'ai de mes yeux vu! A-t-elle au contraire augmenté de fréquence? Je le crois fermement"—an impression which is shared by M. Fournier's colleagues, who have unanimously declared "Des syphilitiques on en voit aujourd'hui partout et plus que jamais." M. Fournier adds, syphilis is flourishing in Paris to-day; it abounds and surabounds; the special hospitals are not large enough for the numerous cases, which overflow into the general hospitals. All this shows how impotent are the Police des Mœurs, so far as the repression of syphilis (the only venereal disease of any consequence) is concerned. He adds, "Telle est en effet la stricte vérité des choses." All this is evidently the direct result of the system we are asked to introduce into England. With what object? To stamp out syphilis. Is it not too ridiculous?

I am, Sir, yours truly,

C. BELL TAYLOR, M.D.

THE RISKS OF UNOPERATED FIBROMYOMA.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Will you permit me to correct an error which appears in my paper on "The Risks of Unoperated Fibromyoma," in your last week's journal. The specimen, No. 2951A. in the St. Bartholomew's Hospital Museum is not, Dr. Griffiths informs me, taken from a case of uterine fibroma but of carcinoma. The specimen is, however, still very worthy of study as showing, perhaps better than any museum specimen with which I am acquainted, the ravages caused by pelvic peritonitis and the difficulties which it imports into any case requiring surgical interference in that region. Inasmuch as such pelvic peritonitis is a comparatively rare thing in carcinoma, whilst extremely common in old fibromyomata complicated, as it so often is, with inflammatory changes in the appendages, the lesson it teaches is very useful in connection with this subject.

May I ask you to make this correction in your next issue.

I am, Sir, yours truly,

G. STANMORE BISHOP.

316, Oxford Road, Manchester,
February 19th, 1900.

Obituary.

DR. WILMOT, OF DUBLIN.

THIS most estimable and respected gentleman died at his residence in Kingstown on the 17th inst., one of the few remaining links between Irish surgery in the past and in the present being thus severed. Samuel George Wilmot commenced the study of his profession at Steven's Hospital under the guidance of Abraham Colles, James Cusack, and others, whose skill and industry made Irish Surgery of that day notable. He took his first qualification in 1842, served as resident surgeon of his hospital, and through all grades until he became its

consulting surgeon. His M.D. was derived from the University of Aberdeen in 1846, and he took the Fellowship of the Royal College of Surgeons of Ireland in 1844, becoming ultimately its president. He was a special authority on affections of the urinary system, and wrote several papers on that subject. Dr. Wilmot was greatly esteemed by his brethren as a most kindly and honourable man, and his death leaves many regrets.

Literature.

TAYLOR'S EXTRA-UTERINE PREGNANCY. (a)

WE accord a hearty welcome to the appearance in book form of Mr. Taylor's Ingleby Lectures on extra-uterine pregnancy. These lectures formed the most important contribution to the subject that had appeared for some years; and in their present form they are fuller and more complete than when they were delivered. On some points Mr. Taylor has done pioneer work; especially in the elucidation of the difficult question of abdominal pregnancy, and the ways in which it may arise out of a pregnancy primarily tubal and secondarily mesometric. The distinction which he draws between the anterior ligamentary or sub-peritoneo-pelvic, and the posterior ligamentary, or retro-peritoneal forms of pregnancy was new and important. The two forms had been already described, but they were not recognised as definite modes of development of ligamentary pregnancy. Mr. Taylor rejects the view that a pregnancy may be primarily abdominal, contending that in every case the first seat of impregnation is the tube. In connection with this we may mention his view that invagination occurs normally in the tube; this is at variance with the view of some authors that impregnation only occurs normally in the uterus, and that if it occur in the tube it leads to extra-uterine gestation. Ovarian pregnancy is regarded by Mr. Taylor as theoretical only; he points out that careful elimination of several fallacies is necessary before the fact of ovarian pregnancy can be considered as established in any given case. The directions for operative treatment are given fully, and form a trustworthy guide to the intending operator. We can say without hesitation that no surgeon or gynaecologist can afford to be without this important monograph. On one point our criticism must be unfavourable, and that is in regard to the illustrations. Many of these are very poor, and quite unworthy of the excellence of the text. We hope that the reception of the book may be such as to call forth another edition; and that when this is contemplated the illustrations will be brought up to the standard required by the importance of the work.

BISSET'S PSYCHOLOGY OF REASONING. (b)

M. BISSET alleges that his psychology of reasoning is based on experimental researches in hypnotism. The psychic revelations of the hypnotic state are, indeed, very suggestive, but their value as data in a constructive system of psychology must, in not a few instances, be doubtful, not only because of the personal equation in the subject, but in the observer as well. The first chapter, dealing with the syllogism and the definition of perception, is clear and explicit. He disputes the syllogism of the ancient logicians, which affirms that a group of three propositions, the first of which is general, constitutes a proof, and in doing so he but re-echoes Stuart Mill. His aim is to show further that numerous, though always particular facts are the real premises of reasoning, the real proofs of the conclusion, "so that the conclusion is not contained in the premises; it is distinct from them, and adds something more to them. This idea, which is so appropriate, simple and natural, explains how reasoning constitutes a development of know-

(a) "Extra-Uterine Pregnancy: A Clinical and Operative Study." By John W. Taylor, F.R.C.S., Surgeon to the Birmingham and Midland Hospital for Women, &c. London: H. K. Lewis, 1899.

(b) "The Psychology of Reasoning." By Alfred Bisset. Translated from the second French edition by Adam Gowans White, B.Sc. Chicago: The Open Court Publishing Company.

(a) "Bulletin de l'Académie de Médecine," No. 39; Séance du November 14th, 1899. P. 475.

ledge." The author demonstrates with force and illumination that the fundamental element of the mind is the image, that reasoning is an organisation of images. In proceeding further to elucidate this point, M. Bisset defines perception, adopting the definition of English psychologists, as "the act which takes place when our mind enters into relation with external and present objects." The author is careful to emphasise this truth that in every act of perception the mind constantly adds to the impressions of the senses, thus:—"Everybody knows that we can hear the words of a familiar song clearly, while we are unable to distinguish those of an unknown song, even when both songs are sung by the same voice, a fact which shows the share due to the mind." We might review further, but space forbids. So far, we are on common ground with the author, but there are debatable questions beyond. At the same time we think the book is full of interesting and suggestive reading, and a valuable contribution to psychology.

THE EDINBURGH MEDICAL JOURNAL. (a)

DR. GIBSON has every cause to be satisfied with the success of the *Journal* which he so ably edits. Every one of its six hundred pages is worth reading, and on each the wants of the practitioner of medicine are kept well in view. Not the least valuable papers are the reports on Therapeutics by Dr. Stockman, Dr. Thompson's report on Surgery, and the analytical reports.

Among the clinical records we find Dr. Miller's wonderful "crowbar" case, which, like the "crowbar" case of Dr. Biglow, will probably become classic. Dr. Littlejohn publishes some valuable medico-legal works on suicide which will repay the reading.

Dr. Crum Brown publishes a charming biographical sketch of Dr. John Mayow, that great Cornish student of nature, who foreshadowed the discovery of oxygen, if the isolation of the element be not credited to Robert Hooke, who in his *Micrographia* distinctly pointed to the presence of the element. It is pleasant to note that Hooke proposed Mayow as a Fellow of the Royal Society, and that Beddoes made his works known to his countrymen. All three general practitioners; all three practising medicine as a profession, and all three finding leisure to extend the boundary of the known. They have each written their name on the record of fame.

Space does not allow of our doing more than mentioning the many beautiful illustrations that adds so much to the value of the letterpress.

MORISON'S RELATION OF THE NERVOUS SYSTEM TO DISEASE AND DISORDER IN THE VISCERA. (b)

THIS volume comprises the Morison Lectures delivered before the Royal College of Physicians, Edinburgh in 1897 and 1898. These lectures are usually given on insanity, but in the present instance the author, a relation of the founder, has of necessity, owing to inexperience of mental diseases, to go further afield, and naturally takes up the subject of the nervous system and visceral disease, to which he has devoted some attention. On looking over these lectures one is impressed with the fact that they are largely a repetition of what we already know, and that they are less original than we should expect in Morison Lectures. It certainly must be difficult to find the time to pursue original investigation to such an extent as will furnish a complete set of original lectures, though we are bound to say that Dr. Morison has done some independent work, and procured some excellent illustrations for these lectures. But in our search and anxiety for something new, something to bring us appreciably nearer the goal of our therapeutic expectations, how far onward does this

work bring us? We confess to a feeling of disappointment, for we rise from the perusal of the book with an impression that much has been attempted and little attained. Dr. Morison has done his best to qualify himself for microscopic research, and he is honest in his admissions of failures. He has certainly added to our knowledge of the innervation of the viscera, but the great bulk of this subject is to a large extent a terra incognita, and many of the views entertained on the subject are of uncertain value, or of no value at all, by reason of the conflicting histological results. The last lecture, "On Body and Mind," teaches nothing new, but is rather a compendium of quotations. The author is not careful as to terminology when he speaks of the "profound melancholy of the religious maniac." His appendix on the "Innervation of the Intercranial Vessels" is of more practical importance and value than the greater part of the lectures. Some of the illustrations, of which there are several, are very good.

Medical News.

A Sceptic on Malarial Infection.

A ONE-TIME resident for many years on the West Coast of Africa, communicates to a friend certain criticisms on recent investigations bearing on the spread of malaria which are sufficiently original to deserve notice. He says, "As regards the theories recently propagated, I think—in fact, I feel sure—that Major Ross's ideas are quite wrong. He states that by exterminating the malarial mosquito, the whole malarial question can be settled. To my mind, there was never such an error. Now, when I first came to this tropical part, and was attacked with fever, I am perfectly certain that I never had been bitten by a mosquito of any sort, and slept under a mosquito curtain constantly as a precaution. There is an assistant clerk here who has been bitten and re-bitten; he has lived in places where swamps are the only tracts of surface on which to dwell, yet he has never had the fever, although he has been here three years. I am positive that if you came out, and always used a mosquito curtain, and took every precaution, you would still be liable to malaria. Even supposing the mosquito was one of the causes of transmitting malaria, it is a mere detail, considering there are millions of insects capable of breeding germs equally infectious; yet the doctor proclaims that he has discovered the malaria mosquito, and that it is only a question of the Government exterminating the pest to allow Europeans to live in perfect health in the tropics. How can the Government extirpate millions upon millions of insects that can breed, in swamps, much faster than they can be destroyed? Can you imagine a deputation to inquire into this scourge coming out here to the seat of the trouble, and as soon as it arrives there is a statement made by Dr. Ross, 'I have discovered the malarial mosquito!' The Expedition was back in England again in about a month, and professed to know all about this disagreeable and relentless mosquito! How was it possible to study and find by investigation all concerning the cause of malarial fever in a few weeks? If the deputation was anxious to benefit mankind, it would at least have stopped on the coast six months."

Small-Pox in Basutoland

SMALL-POX is reported to be spreading rapidly in Basutoland, and much difficulty is experienced in enforcing measures having for object to check its spread.

A Fictitious L.S.A.

A PERSON called Holmes was sentenced to three months' imprisonment at the Central Criminal Court last week for having, in giving evidence in a civil case, falsely sworn that he was a licentiate of the Society of Apothecaries, and was duly qualified, whereas it appeared on making enquiry, that the diploma bearing the name of Holmes could not by any possibility have been gained by the defendant. Though the delinquent in this instance received the punishment he deserved, the case shows with what comparative ease the privileges of

(a) "The Edinburgh Medical Journal." Edited by G. A. Gibson, M.D., F.R.C.P. Ed. New Series Vol. VI. Edinburgh and London: Young J. Pentland 1899.

(b) "The Relation of the Nervous System to Disease and Disorder of the Viscera." By Alexander Morison, M.D. Edinburgh and London: Young J. Pentland.

a diploma-holder may be usurped by unscrupulous persons.

Army Medical Nominations.

THE authorities have placed a nomination to a commission in the Royal Army Medical Corps at the disposal of the Catholic University School of Medicine in Ireland.

The British Congress on Tuberculosis.

A MEETING of the Organising Council of the British Congress on Tuberculosis will take place at the rooms of the Royal Medical and Chirurgical Society, 20, Hanover Square, to-morrow (Thursday) at 4 p.m.

Payment of Consulting Surgeons at the Front.

IN answer to a question in Parliament last week the Under-Secretary for War stated that the remuneration in each case is at the rate of £5,000 a year, with free passage to Africa and back.

The Lunacy Bill.

THE Lunacy Bill brought forward by the Lord Chancellor has been read a second time in the House of Lords. It will be remembered that this Bill, which has passed the House on two previous occasions, deals with several points of considerable public importance, one of the most noteworthy being provisions relating to urgency orders which were instituted by the Act of 1890. It is stated that the facilities given by this form of procedure have been abused, and in the interest of the liberty of the subject it is urged that an amendment of the law is desirable.

Isolation Hospitals.

THE Earl of Lichfield's Isolation of Hospitals (Amendment) Bill has been read a second time in the House of Lords, and Lord Harris, on behalf of the Government, promised that it should be brought to the notice of the Local Government Board with the object of submitting to the House of Commons. The object of this Bill is to amend the Isolation Hospitals Act, 1893, with a view to improving the facilities for the provision of sufficient isolation hospital accommodation. The Act of 1893 empowered county councils to provide isolation hospitals and to group districts together for that purpose. The Local Government Board, however, had decided that where a local authority had already provided sufficient hospital accommodation, although it was willing to be included in a hospital district, it could not sell or lease its existing hospital to a hospital committee constituted under the Act of 1893. It is chiefly to remedy this that the Bill has been introduced.

The Dublin Death-rate.

WE are gratified to note that the mortality rate of Dublin, which recently touched 51.1 per 1,000 of the population, has fallen in successive weeks to 29.1. Zymotic deaths are still in excess of average, and chest diseases still more so.

British Medical Benevolent Fund.

THE annual general meeting was held on February 13th, at the residence of Sir William Broadbent, Bart., who occupied the chair. The hon. secretary for finance presented the report of the committee and the treasurer's financial statement for the past year. In the grant department, subscriptions amounting to £892 ls. 9d., and donations amounting to £399 10s. 9d., had been received, and £1,539 10s. had been distributed in sums varying from £5 to £20 to 161 out of 216 applicants. In the annuity department the interest on invested capital had yielded £2,334 ls. 1d., of which £2,203 5s. 10d. had been paid to recipients of the age of sixty and upwards, whilst the capital had been increased by legacies amounting to £1,457 6s. 9d. Ten vacancies caused by death had been filled, and one new annuity created, bringing the number of annuitants up to 109. The accounts of the Fund had been, as usual, audited by a chartered accountant, who drew special attention to the extremely small working expenses, which for the past, as for many years, had been less than five per cent. The death of Sir James Paget, Bart., for many years the honoured president of the Fund, was sympathetically referred to, and Sir Wm. Broadbent unanimously elected to the vacant office, and Dr. Samuel West to that of treasurer. Attention was drawn to the serious

decrease of subscriptions and donations which had occurred during the year, and a hope expressed that fresh effort would be made by all interested in the Fund to remedy the deficiency. The meeting concluded with a vote of thanks to the Chairman, and to the MEDICAL PRESS AND CIRCULAR for the support always given to the charity.

The International Medical Congress, Paris, 1900.

THE Paris Executive of the International Medical Congress give notice that as there has been some misunderstanding about the sectional arrangements every member may join as many sections as he pleases for a single subscription, but that the expense will prevent every member receiving a copy of the whole twenty-four volumes of the proceedings of the Congress. Each member of the Congress will receive therefore in due course:—(i.) A general resumé of the work of the Congress. (ii.) A volume of the Acts of the Congress. (iii.) A volume containing the works of the section to which he chooses to affiliate himself. If a member has joined several sections he will receive the proceedings of the section which he has placed first on his form of application for membership. Members of the Congress who wish to receive the whole set of proceedings should communicate with M. Masson, the Editor, 120, Boulevard St Germain, Paris.

The Irish Official Reports.

THE annual reports of the Irish Local Government Board and of the Registrar-General of births, deaths, and marriages for Ireland, for the year 1899, appeared last week. The former, for this occasion, is a ponderous tome of over 900 pages, crowded up with all the circulars, regulations, and correspondence incident to the new Irish Local Government Board Act. The Registrar-General's report is much in the same form as usual, and we receive it with much regret as the last bequest to Ireland of a useful and meritorious life official Dr. Grimshaw. We shall note both publications next week.

Dublin University.

THE Examiners appointed for the ensuing year are—in Medicine, Dr. Craig, of the Meath Hospital, and Dr. Drury, of Cork Street Hospital; in Surgery, Mr. Heuston, of the Adelaide Hospital; in Midwifery, Dr. Henry Jellett; and in Ophthalmology, Dr. J. B. Story.

School Board Exigencies.

WE have not the slightest wish to offer any hindrance to the school board officials in their endeavours to secure the regular attendance of the scholars, but medical practitioners, on the other hand, are entitled to a certain amount of consideration when called upon to certify the inability of patients to put in an appearance at school. More especially is this the case in regard to hospital medical officers, whose time is far too valuable to be wasted in filling up detailed certificates. We are glad to see that Mr. Franklin, of the Royal Westminster Ophthalmic Hospital, took advantage of a recent opportunity to enter a public protest against what he rightly described as the unreasonable exigencies of the London School Board. It seems that a lad under treatment at the hospital had been summoned for non-attendance, in spite of Mr. Franklin's certificate that the patient was temporarily unable to attend school, apparently on the ground that the officials decline to recognise a certificate in any other than the prescribed form. Under the circumstances the magistrate declined to inflict a fine, and it is to be hoped in future the School Board officials will show themselves less hide-bound in this matter.

Indian Medical Service.

THE following is the official list of candidates for her Majesty's Indian Service who were successful at the Competitive Examination held in London on February 2nd, 1900, and following days, arranged in the order of merit:—

Graham, J. D.	3,640	Oxley, J. C. S.	2,615
Sprawson, C. A.	2,836	Macnee, H. E.	2,560
Cazaly, W. H.	2,828	Lapsley, W.	2,524
Coppinger, W. V.	2,812	Kays, W. D. A.	2,497
Browne, P. A.	2,785	Chalmers, A.	2,459
Spitteler, A.	2,768	Good, J.	2,453
MacKellie, M.	2,651	Houston, W. W.	2,402
Deas, L. J. M.	2,621	Young, G. J. G.	2,363
Hamilton, W. G.	2,620	Godkin, S. B.	2,262

Notices to Correspondents, Short Letters, &c.

✎ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a distinctive signature or initials, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

FEMALE MEDICAL STUDENTS AND MIXED CLASSES.

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—In your "Notices to Correspondents," &c., for this week, referring to female medical students in Paris, you speak of the "ill-bred manifestations of dislike which characterise the conduct of male students in this country when mixed classes are attempted." This sentence is a little too sweeping. I can only speak for my own college and the hospital of my own city, and here I can safely aver that the Cork male students have always treated the female students in that spirit of gentlemanly comradeship which is the perfection of male courtesy. More than that, the appeals to the Board of the South Infirmary which procured the opening of its clinical teaching to women were organised and carried through almost entirely by male students, who did not rest till they had procured full educational advantages for their female comrades whom they had learned to know in the lecture rooms of the Queen's College Cork. How it may have been in other medical schools I cannot say.

I am, Sir, yours truly,

MARCUS HARTAG, D.Sc., M.A., F.L.S.
Cork, February 16th, 1900. Prof. Nat. His.

J. V. R. (Aylesbury).—Alcohol, in the form of whisky or brandy, is recommended as an antidote in carbolic acid poisoning, a treatment which is dealt with editorially in the present issue. Vinegar or dilute acetic acid in equivalent strength is also highly spoken of.

WARNER'S SAFE CURE.

H. H. WARNER, of New York, formerly head of the Safe Cure Company, and a reputed millionaire, is, according to an American contemporary, in the Bankruptcy Court. He owes 2,319,027 dol., and has no assets, but there are thirty-three judgments registered against him.

DR. F. F.—Medical practice in Honduras is reported to be at a low ebb. There are no openings, indeed, we are informed that several practitioners there are anxious to find openings elsewhere.

PUBLIC LAVATORY ACCOMMODATION.

A CORRESPONDENT referring to our comments on the lack of adequate public lavatory accommodation, especially for women, sends us the following effusion:—

Perhaps you're not aware, but I hardly think it fair,
Hence the reason I have taken up my pen,
But at every railway station they charge accommodation
For ladies, but no charge is made for men.

If the "water rate" enforce, charge the men as well, of course,
And so increase the company's large gains,
For surely there are many cannot pay the humble penny,
And so must suffer silently their pains.

A. D.

Meetings of the Societies and Lectures.

WEDNESDAY, FEBRUARY 21st.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 p.m. Mr. B. G. A. Moynihan: The Anatomy and Pathology of some Rarer Forms of Hernia. (Arris and Gale Lecture.)

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester Square, W.C.).—4.30 p.m. Dr. M. Dockrell: Syphilides. (Post-graduate Course.)

FRIDAY, FEBRUARY 23rd.

CLINICAL SOCIETY OF LONDON (20, Hanover Square, W.).—8.30 p.m. Clinical Evening. The following cases will be shown:—Dr. St. Clair Thompson: Primary Tuberculosis of the Nasal Septum (shown at the Society in October, 1897).—Mr. J. Clarke: A Case of Lateral Curvature of the Spine in an Infant.—Mr. Battle: Patient after Removal of a Portion of Skull for Malignant Disease.—Mr. Battle: Patient after Open Section of Knee-Joint for Irreducible Traumatic Dislocation.—Mr. Kellock: A Case of Achondroplasia.—Dr. C. W. Chapman: Two Cases (father and son) of Congenital Deformity of the Hands, with Absence of Radius in the Child. Other cases will be shown. Patients will be in attendance at 8 p.m.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 p.m. Mr. B. G. A. Moynihan: The Anatomy and Pathology of some Rarer Forms of Hernia. (Arris and Gale Lecture.)

Appointments.

AUNGIER, MARK, M.B. Ch.B. Vict., Senior House Surgeon to the Bootle Hospital, Liverpool.

BAYLISS, RICHARD ARTHUR, L.R.C.P. Lond., M.R.C.S., Honorary Medical Officer to the Eastern Dispensary, Bath.

BERRY, H. POOL, M.B. Lond., M.R.C.S., Medical Officer of Health for the Grantham Urban Sanitary District.

BUSHNELL, F., M.D., B.S. Lond., L.R.C.P., D.P.H., M.R.C.S., Pathologist to the South Devon and East Cornwall Hospital.

CHATELIER, EUGENE, J. A., M.B., C.M. Edin., Medical Superintendent to the City Hospital, Birmingham.

CLAY, B. H., M.D., M.R.C.P., L.R.C.S. Edin., Physician to the South Devon and East Cornwall Hospital.

CURRIE, JOHN R., M.A. Edin., B.A. Oxon., M.B., Ch.B. Glasg., Indoor Resident House Surgeon to the Glasgow Maternity Hospital.

HARRIS, S. C., L.F.P.S. Glasg., Medical Officer of Health for the Ely Urban Sanitary District of the Ely Union.

HUTCHINSON, GEORGE ARNOLD, M.R.C.S., L.R.C.P., Assistant Officer to the Glamorgan County Asylum, Bridgend.

JAMES, ALFRED HUGH, M.B., C.M. Edin., House Surgeon at the Aberystwyth Infirmary.

JAMES, W. D., M.R.C.S., Surgeon to the Ecclesall Division of the Sheffield police.

JOHNSON, R. G., L.R.C.P., M.R.C.S., Assistant Medical Officer to the North London Hospital for Consumption, Hainstead.

LINDSAY, Professor J. A., M.A., M.D., M.R.C.P. Lond., Examiner in Medicine, Royal University of Ireland.

LUCY, R. H., F.R.C.S. Eng., M.B., C.M. Edin., Surgeon to the South Devon and East Cornwall Hospital.

MCWERNY, E. J., M.D. Irel., L.R.C.P., D.P.H. Irel., Bacteriologist to the Irish Local Government Board.

PEARSON, JOSEPH, M.B., C.M. Aberd., Surgeon to the Broomhill Division of the Sheffield police.

RENDLE, C. E. RUSSELL, B.A. Oxon., L.R.C.P., M.R.C.S., Assistant Surgeon to the South Devon and East Cornwall Hospital.

STAUNTON-CAHILL, CHARLES, J., L.R.C.P., L.R.C.S. Irel., Junior House Surgeon to the Bootle Hospital, Liverpool.

THOMPSON, Professor, W. H., M.D., F.R.C.S. Eng., an Examiner in Physiology in the Royal University of Ireland.

WEBBER, H. W., M.S., M.D., L.R.C.P., M.R.C.S., Assistant Surgeon to the South Devon and East Cornwall Hospital.

WHIPPLE, CONNELL, L.R.C.P. Lond., M.R.C.S., Surgeon to the South Devon and East Cornwall Hospital.

Vacancies.

Bath General or Royal Mineral Water Hospital, Bath.—Resident Medical Officer, unmarried. Salary £100 per annum, with board and apartments in the hospital.

Burton-on-Trent Infirmary. House Surgeon. Salary £150 for the first year and £170 for the second year, with furnished rooms in the Infirmary, and coals and gas free.

Carmarthen Infirmary.—Resident Medical Officer, unmarried, for twelve months. Salary £100 per annum, with furnished apartments, board, attendance, fire, gas, and washing.

Castlereagh Union.—Trained Infirmary Nurse. Salary £50 per annum, with rations and apartments. Application to M. F. Flanagan, Clerk of the Union.

Consumption Hospital, Ventnor.—Assistant Resident Medical Officer to the Royal National Hospital for Consumption. Salary £100, with board and residence. Immediate application to Dr. Parry. (See Advt.)

County Borough of Stockport.—Medical Officer of Health for five years. Salary £400 per annum, increasing annually by £25 to £500. Apply to the Town Clerk, Town Clerk's Office, Stockport.

Durham County Asylum.—Assistant Medical Officer, unmarried, Salary £140, rising by yearly increments to £160 with board, lodging, washing and attendance. Apply to the Medical Superintendent, Winterton, Ferryhill.

Glasgow Lunacy District Board.—Medical Officer (Assistant) for Woodilee Asylum, to act as Pathologist. Salary £100 per annum, with board, apartments, &c.

Great Northern Central Hospital, Holloway Road, London.—Assistant Anaesthetist for six months. Honorarium at the rate of 10 guineas per annum. (See Advt.)

Mercer's Hospital, Dublin.—Resident Medical Officer. Applications to the Registrar of the Hospital. (See Advt.)

Mercer's Hospital, Dublin.—Vacancy on the Surgical Staff. Applications to the Registrar of the Hospital. (See Advt.)

Queen's College, Cork.—Professorship of Materia Medica. For particulars, of the Under Secretary, Dublin Castle. (See advt.)

Sunderland Infirmary.—House Surgeon. Salary £20, rising £10 annually to £100, with board and residence.

University College of South Wales and Monmouthshire.—Demonstrator and Assistant Lecturer in Anatomy. Salary £120.

Marriages.

GRAYLING—PERKINS.—On February 15th, at Stratford-on-Avon, Arthur Grayling, M.B. Lond., of Forest Hill, S.E., to Nellie, second daughter of W. E. Perkins, Esq., J.P., of Astwood Bank Worcestershire.

HARRATT—NOAD.—On February 15th, at St. Andrew's Church, Fulham, Henry Harratt, M.R.C.S., L.R.C.P., of Elmside, Northam, Sussex, to Winifred Beatrice Innes, second daughter of the late Stephen Innes Noad, of Chigwell Row, Essex.

HEELAS—DENTON.—On February 15th, at Christ Church, Tekenhall Wood, Walter W. Heelas, M.R.C.S., L.R.C.P., of Wolverhampton, to Jessica, daughter of H. E. T. Denton, Esq., J.P., of Tekenhall Wood.

TOMBLESON—LIVINGSTON.—On February 14th, at St. Mary's, Spring Grove, Isleworth, James Bennett Tombleson, M.B., B.Ch. Oxon., Spring Grove, to Eleanor, youngest daughter of James Livingston, Esq., of Claremont House, Isleworth.

Deaths.

CUNDELL.—On February 11th, at his residence, Brunswick House, Kew, George R. Cundell, M.D., J.P.

GIBB.—On January 27th, at Kingston, Jamaica, Robert Chas. Gibb, M.R.C.S., L.R.C.P., aged 49 years.

HEATH.—On February 15th, at Exminster, Devon, aged 34, Alan Jasper Heath, M.D. Lond., Captain in the Indian Medical Service (Bombay), second son of Christopher Heath, F.R.C.S., of London.

HYDE.—On February 8th, Samuel Hyde, M.D., of Lismore House, Buxton, Derbyshire, aged 50 years.

KIDDLE.—On February 9th, at Mongkwa, Burmah, murdered by natives, Major Walter Kiddle, M.D., Royal Army Medical Corps, L.R.G.C.P.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXX.

WEDNESDAY, FEBRUARY 28, 1900.

No. 9.

Original Communications.

TUBERCULOUS TROCHANTERIC DISEASE.

WITH A REPORT OF FOUR CASES.

By J. BASIL HALL, M.C. Cantab., F.R.C.S.E.,
Visiting Surgeon to the Bradford Union Hospital.

TUBERCULOUS disease of the trochanter of the femur is a comparatively uncommon condition occurring in childhood or early adult life. Strictly speaking the term "disease of the trochanter" is a misnomer, for the deposit of tubercle, so far as my observation goes, is always situated inside the line of junction between the trochanter and the bone, and, therefore, lies in the base of the neck of the femur rather than in the trochanter itself. The tuberculous process seems to be invariably that of sequestrum formation, as described by Cheyne under the name "necrosis with sclerosis." Whether suppuration occurs or not, the condition tends to become quiescent, the tuberculous sequestrum remaining embedded in the bone. Years after, in adult life, vague symptoms develop without any apparent exciting cause, or possibly attributable to some slight injury. So-called chronic rheumatism, aching pain in the hip and thigh with no very evident gross lesion, may continue to perplex both doctor and patient. These symptoms may persist indefinitely, but usually suppuration sooner or later appears, and operation clears up the diagnosis.

During the last few years I have seen five such cases, in each of which the patient had endured more or less pain and discomfort over a prolonged period. In some instances there is no great degree of suffering, but the patient will say that his symptoms are a perpetual nuisance to him. Any little extra exertion brings on pain. His hip and thigh aches at the end of the day, sometimes spoiling his sleep at night. The limb feels stiff first thing on rising in the morning. The uselessness of all treatment worries and depresses him. His objective symptoms are so easily overlooked that his medical man is misled into thinking that he exaggerates his pain. If suppuration has occurred in early life when the sequestrum first formed, the true condition may be suspected, but in some of the cases there is no such clue. There are, however, certain symptoms present which will be found if carefully looked for, and it is with the object of drawing attention to these that I record the following cases.

CASE 1.—Miss L., *æt.* 38, was brought to me in June, 1899. She complained of constantly recurring pain of an aching character in the right thigh which had been troubling her for nearly six years. Slight and often absent when resting, it became very troublesome if she walked about very much or undertook hard work. Dull aching pain generally set in at the end of the day. The limb felt stiff and painful when she first got out of bed in the morning. At

times she feels quite well, at others she is forced to limp.

When four years old she had a severe illness, of which she remembers nothing except that she was carried up and down stairs for six months and had suppuration about the right hip.

Condition when seen.—Healthy-looking woman who walks with a very slight limp in the right leg. When recumbent, the attitude is normal. There is no eversion, nor flexion at the hip-joint. The movements are free except that extreme flexion is a little restrained. Abduction and rotation are painless. There are no enlarged glands. Percussion on the heel is painless. On the outer side of the thigh is an old scar half way between the hip and knee-joint. It is only faintly marked and of small size. The trochanter feels rather larger and more massive than that of the opposite side. This is not due to muscular wasting, as the limbs are equally developed. The enlargement seems to be in an antero-posterior direction, as there is no prominence of the trochanter visible to the eye. The thickening is best felt by grasping the bone with the fingers and thumb in front and behind, whilst the other hand is similarly employed on the other limb. Percussion over the trochanter is painless, but at one spot close to the posterior border doubtful tenderness is elicited on deep pressure. There is no fulness in front of the hip-joint, and no wasting of the gluteal fold.

On July 31st, under ether, the trochanter was exposed by a free vertical incision, and the tissues peeled off it. The surface of the bone appeared healthy. I opened up the cancellous tissue immediately below the insertion of the gluteus medius. The whole trochanter and neck of the femur was excavated by means of a gouge. The bone was soft, spongy and vascular. In the neck of the femur at its base was a yellow non-vascular sequestrum about the size of a horse bean. There was no sign of any pus, but just above the sequestrum was a small circumscribed area of condensed bone, in striking contrast to the somewhat rarefied tissue about it. The whole cavity was packed with iodoform gauze. There was no pain after the first day, and the patient made a rapid recovery.

CASE 2.—J. G., *æt.* 27, was brought to me in February, 1899. He gave the following history. As a child he suffered from an abscess in front of the right thigh, which closed spontaneously after discharging for some months. He thinks that his leg has never been quite right since then, as he has often noticed slight aching pain after much exertion, but until lately it has been insignificant. About three years ago he began to have more marked symptoms, aching pains in the thigh, especially towards the end of the day, and sometimes keeping him awake at night. At the end of twelve months the pain had become so troublesome that he went into hospital. The hip was examined under ether, but he does not know what opinion was arrived at. Twelve months later he was re-admitted, and an incision made over

the trochanter but no bone removed. For the following twelve months he alternately worked and rested in bed. He lost weight, and became pulled down from disturbed sleep and constant pain. Six weeks prior to my seeing him a small swelling appeared in front of the thigh at the site of the old abscess scar from which some matter escaped.

Condition when seen.—Thin, pale, and in poor health; walks with a decided limp. In front of the right thigh, eight inches below the trochanter, is a small opening just internal to the tensor vagina femoris, from which the pus has escaped. The attitude of the limb is normal. The movements of hip, though somewhat restrained, are practically painless. There is no arching of the back on extension, and abduction and rotation are painless. Flexion is limited. There is no shortening of the limb, real or apparent. There are no enlarged glands. The gluteal fold is not obliterated, but the limb generally is somewhat wasted. There are no starting pains at night, but constant aching about the hip and thigh. On comparing the trochanter with that of the opposite side, it feels slightly thicker and more massive, and pressure with the fingers elicits deep tenderness. There is, however, an absence of that fulness in front of the hip-joint which is usually found in hip disease. The thickening of the trochanter is most evident when the bone is grasped as in Case 1. Percussion on the heel is painless.

On February 9th, under ether, the trochanter was exposed by a free vertical incision. On the surface of the bone was a small cloaca blocked by a bud of granulation tissue. A sinus travelled forwards beneath the tensor vagina femoris towards the front of the thigh. The outer wall of bone having been cut away with a chisel, the whole trochanter and base of the neck of the femur was cleanly hollowed out with a gouge. The cancellous tissue was soft, spongy and vascular, showing evident rarefying osteitis. Two small sequestra were found imbedded in the base of the neck of the bone. They were yellowish in colour and contrasted strongly with the vascular tissue in which they lay. Immediately surrounding them was a thin layer of granulation tissue. The cavity was packed as in Case 1. The sinus in front of the thigh was slit up, scraped, and flushed out, and finally stitched. During the first twenty-four hours he had some pain, which was relieved after the first dressing. Four days later he said he had lost all his aching pain, and that for the first time for two years he could sleep soundly. The cavity quickly filled up, and he put on flesh rapidly. He left the surgical home at the end of a month.

The remaining cases I can briefly dismiss with a few words, as they are in most respects similar to those recorded above.

CASE 3.—A man, 35 years of age, who had suffered from aching pain in the right thigh for six years. This was supposed to be due to "chronic rheumatism," and he had undergone various courses of treatment. It had also been suggested that stretching the anterior crural nerve might give relief. Finally he had appealed to a "quack," who had to some extent relieved him by blistering. There was in this case an entire absence of any sign of hip disease, neither could I satisfy myself that the trochanter was enlarged. I proposed, however, that the bone should be explored, and to this he readily agreed. I found and removed a small sequestrum very similar to that in Case 1. The patient was at once relieved of his pain, and is now quite well.

CASE 4.—The patient was a man of middle age with suppuration about the left hip, and a similar case in many respects to Case 2. He had complained for many years of rheumatism in the limb, and had been worse after a fall eighteen months prior to my seeing him. When I first saw him there was decided

thickening of the trochanter and some tenderness on firm pressure, but no signs of suppuration. I advised operation, but he refused to have anything done. Six months later I saw again, when there was present a large abscess beneath the gluteus and tensor vagina femoris. He also had a cavity at the apex of the lung with well-marked symptoms of phthisis. Under these circumstances I decided to aspirate the abscess and inject it with iodoform emulsion in order that, if possible, it might be reduced in size before opening it. This treatment was eminently successful. After eight aspirations and injections the abscess was almost obliterated, having shrunk from a capacity of 22 ozs. to that of 3 ozs. Under chloroform I then exposed the trochanter and removed an old tuberculous sequestrum from the base of the neck of the femur. The case did well, and the patient is now, I believe, in South Africa.

In each of the cases just quoted there seems to have been an osteitis going on round an old tuberculous sequestrum which had remained embedded for many years in the cancellous tissue at the base of the neck of the femur. These sequestra have been described by Cheyne, König, and others.

The history of their formation seems to be that, as a result of a deposit of tubercle there is an inflammatory reaction set up in the neighbourhood; the cancelli becoming filled with young vascular tissue, thickening and new formation of osseous trabeculae occurs. A patch of sclerosed bone results; the tuberculous deposit, extending at the margins, finally caseates. There comes to be, therefore, a small island of sclerosed bone surrounded by caseous material and without blood supply. Should the tuberculous disease cease to spread at the margins, the sequestrum remains, imbedded and the condition lapses into a quiescent state. After a long and indefinite period of quiescence, possibly as a result of some slight injury, a sequestrum may commence to set up a rarefying osteitis around it which will ultimately end in suppuration unless steps be taken to remove it. The cases first quoted may be taken as characteristic types of this recrudescence of the disease, and as such present several features in common.

First, the presence of persistent long-continued aching pain in the thigh, not referred to the knee, aggravated by prolonged standing or exertion, and usually worse at night.

Secondly, the absence of any definite signs of hip disease, particularly pain on abduction and rotation, fulness in front of the joint, and decided muscular wasting and obliteration of the gluteal fold.

Thirdly, some anteroposterior enlargement of the trochanter, possibly very slight, but nearly always present in some degree.

Fourthly, a tender spot in the trochanter (on deep pressure or percussion) is occasionally present.

Lastly, in most of the cases a history of bone disease or symptoms suggestive of it in earlier life, in the affected limb.

The question naturally arises as to whether this condition is a recrudescence of tuberculous disease or merely a simple osteitis set up by the presence of an old sequestrum. In three of the above cases which I have examined I have failed to find the tubercle bacillus, although in all other respects the appearances have been those of tuberculous disease. It is impossible at present to say how long an old tuberculous focus may remain capable of renewing its activity, but there is much evidence to show that recrudescence may occur after very long periods. I have lately seen a case of tuberculous disease of the tarsus which developed after a slight injury. Twenty years previously the patient had been operated upon for disease in the scaphoid and cuneiform bones, and imbedded in these I found, after amputation, an old

sequestrum surrounded by caseous material partially calcified, from which the infection seemed to have occurred.

The operation of excavating the neck of the femur is comparatively simple, easily borne, and quickly recovered from. Care must be taken not to open the joint above nor the medullary canal below. The patient must not be allowed up too soon or fracture may occur. Restoration of function is perfect.

ANTRAL CATARRH AND SUPPURATION. (a)

By J. G. TURNER, F.R.C.S.,
Surgeon to the Dental Hospital, London.

Since the antrum is lined with a mucous membrane continuous with that of the nose and of identical origin, most cases of antral suppuration are cases of muco-purulent catarrh analogous to like trouble in the nose. There is, however, a non-purulent stage, both at the commencement and at the recession of the acuter stage, which is worth recognising. This stage gives rise to symptoms less in degree, but similar to those of the acuter stage, and can be cut short and allowed to get well of itself if the source of trouble be removed and reinforcement of the materies morbi prevented. This makes it important to recognise it. In the receding stage of purulent catarrh the transilluminator shows darkness on the affected side, but I have been unable to satisfy myself that there is appreciable diminution in the early stage.

I will next consider the signs and symptoms of acute and chronic antral suppuration and their causes. I may point out that the pain in either case is due to inflammatory exudation into the tissues themselves and not to pus under pressure. This exudation presses on the nerves, especially the middle and anterior superior dental nerves running in the bony wall of the antrum. Through these nerves the pain may be referred to the supra-orbital nerve at the supra-orbital notch, or to the teeth. This explains why antral pain is so frequently referred to the frontal sinus, though in some cases that sinus itself is diseased and causes pain of itself.

If the ostium becomes blocked either by a plug of muco-pus or by inflammatory swelling of its edges, the pain will be intensified and the pus acts as pus under pressure elsewhere, viz., by boring an exit for itself at the weakest point.

The causes of antral suppuration are to be found in extension from neighbouring sinuses, the frontal and ethmoidal sinuses, and the nose. This latter, especially after fevers or influenza, is far more frequently in trouble; originating round a dead tooth. This may be any tooth, from the first bicuspid, or even canine, to the third molar, the roots of any of which teeth might project into the antrum covered by membrane only. I may mention two cases where teeth, both third molars, started antral suppuration by acting as foreign bodies after being pushed into the antrum in attempts at extraction, one in which suppuration spread from a necrosing tuberosity, and cases where the trouble originated in suppuration of dentigerous or dental cysts, one of the latter being followed by extensive necrosis of the antral walls.

Referring to the use of the transilluminator in diagnosis; the lamp must be placed centrally in the mouth, and both sides compared as to (1) illumination of pupil from within the eye; (2) appreciation of light by patient; (3) amount of light

coming through around lower margin of orbit; (4) amount coming through cheek. This last would be stopped by an ordinary "swollen face," and any solid growth stops light. Stress must be laid on the diagnostic value of a certain amount of swelling, and perhaps capillary injection, of cheek in all cases of chronic antral suppuration. Pain and tenderness alone are not enough—in some cases this is due to turbinate trouble.

The difficulty of treating chronic cases is another point, and I wish to lay emphasis (1) on the condition of the mouth and nose, the mouth especially being surgically a foul cavity in most cases; (2) on the state of the lining membrane of the antrum, which is infected and so infiltrated as to be sometimes over one-third of an inch thick: outside this the bone is chronically inflamed; (3) the shape of the antrum itself with its angular recesses, but especially the cellular nature of the part round the ostium, where cells often extend up on the inner side of the orbit; the frontal sinus may also easily drain into the antrum. Attention, moreover, must be drawn to the danger of infection of the ethmoidal cells from the antrum *via* the cells above mentioned.

I advocate, in chronic cases, that there should be a large opening made in the region of the canine fossa, admitting a finger; that the cavity should be scraped and explored for cellular recesses, swabbed out with pure carbolic, and a big opening made into the inferior meatus of the nose; the cavity packed with iodoform gauze, one end being drawn out through the nostril and the opening into the mouth closed.

After forty-eight hours the plug is to be withdrawn, and if pain or discharge do not occur all may be considered well; but if they do, the communication with the mouth is to be re-opened and the cavity swabbed at intervals with pure carbolic, syringing meanwhile, till pain and discharge cease.

I deprecate the use of drains into the mouth as leaving open a ready avenue of reinfection.

I do not deny that some cases get well with less severe measures, but I have been very impressed with the difficulties of curing a really chronic antral suppuration. Acute cases readily get well once pus is let out and the cavity syringed.

NOTE ON THE USE OF THE VAGINAL PESSARY AS A HELP IN TREATMENT OF UTERINE EROSION.

By ALEXANDER DUKE, F.R.C.P.I., &c.
Cheltenham.

THE hyperæmia co-existing (as a general rule) in cases of erosion of cervix uteri, follicular and otherwise, is certainly conducive to the tardiness of the cure.

By relieving the existing hyperæmia in the first instance by scarification (not puncture), and subsequently by the application of boric acid by vaginal insufflator—the acid being much cleaner and more comfortable to the patient than the glycerine tampon—we are enabled to obtain a much better ultimate result. So far as my experience teaches me the effect of these measures is not lasting enough, and I have had much quicker improvement from the introduction of a well-fitting vulcanite Hodge's pessary in addition. I imagine the splint action of the Hodge, and the support it affords, accelerate the circulation, and so facilitates the healing of the eroded surface.

Indeed, no matter what the true *rationale* may be, I am quite satisfied that the pessary is an important factor in obtaining a more speedy cure, and I have

been surprised to find when observing cases of this nature (where the regular dressings had been applied to os and cervix for a considerable time, with little apparent improvement) in a week or so after introduction of pessary an entirely different appearance of the parts concerned when viewed through speculum.

The prevailing habit with many married women of all classes to resort to various expedients in order to prevent conception, is, in my opinion, a fruitful source of congested uterus, followed by endocervicitis and erosion.

The use of cold water syringing directly after the sexual act (when warm cannot conveniently be obtained) and also the incomplete carrying out of the sexual congress, gives rise to hyperæmia; and this repeated time after time (in ignorance of its mischievous effects) must sooner or later produce the evils spoken of. And it is well for gynecologists to bear this cause in mind when not obtaining the looked-for result in the average time while treating cases of this nature.

I trust that other gynecologists will be able to corroborate my statements after making trial of my suggestions.

THE DILATATIONS AND DIVERTICULA OF THE ŒSOPHAGUS.

By JOHN KNOTT, M.A., M.D., CH B, and Dip.
Stat. Med. (Univ. Dub.); M.R.C.P.I.; M.R.I.A.; &c.

(Continued from page 157.)

IN studying the history and pathology of dilatations and strictures of this rarely-diseased organ, one cannot help being struck with the comparative infrequency of association of widening of the canal above the seat of stenosis. Mackenzie points out that the condition of stricture accompanied by dilatation above the narrowed part is extremely rare, and proceeds to add:—"Among the very large number of cases of cancer of the gullet which I have examined, I have not met with a single example of secondary dilatation." The more limited experience of the present writer has taught him the same lesson. Marchand (*"Néoplasies de l'Œsophage,"* Paris, 1880) collected the accounts of 30 carefully-conducted autopsies, in only one of which dilatation was found above the seat of the (epitheliomatous) neoplasm. In an interesting case recorded by Gradenwitz (1859), the œsophagus of a man who had suffered from dysphagia for 43 years was found dilated above the seat of narrowing, which was situated at the lower end, and presented a considerable degree of thickening. Gouguenheim (1878) published a case of supposed malignant stricture of the œsophagus, in which the walls of the tube above the seat of disease were found both dilated and thinned. In Sir Thomas Watson's classical "*Lectures on the Principles and Practice of Physic,*" a specimen is referred to which presented dilatation above a cancerous stricture of the cardiac orifice of the œsophagus. Bazier (*"Contribution à l'Etude de l'Œsophagisme,"* Paris, 1879) gives the case of a woman who died at the age of ninety of cancer of the stomach, with very pronounced narrowing of the lower six or seven centimètres of the œsophagus, and expansion for some distance above, measuring some centimètres in diameter. Nicoladoni (1877) recorded the case of a little girl of four, who had had the operation of œsophagostomy performed for the relief of increasing dysphagia, which had supervened upon the swallowing of some lye two years before. The result of the operation was fatal, and the middle portion of the tube was found contracted

for about eight centimètres. An irregular expansion of the canal extended for two-and-a-half centimètres above the seat of obstruction. Lindan has described—rather incompletely—a specimen found in the body of a man who had succumbed to the exhaustion produced by increasing dysphagia, which had commenced suddenly about a year before. There was fusiform dilatation of the whole length of the tube, with a rigid constricting band at the lower end. In the middle, where the expansion reached its maximum, the gullet measured 11 centimètres across, and the muscular layers, both circular and longitudinal, were so widely separated as to give the appearance of "a wide-meshed network." Yet the constriction of the cardiac orifice was not so great as to prevent the passage of a sponge probang into the stomach during life.

A peculiarly interesting case of secondary dilatation of the œsophagus was published by West (*Dublin Quart. Jour. of Med. Science*, Feb., 1860), which gained him the credit of being the first writer to establish the probability, if not the absolute certainty, that stenosis of this canal may be of syphilitic origin. Indeed, ever since the publication of his valuable paper on that subject, syphilitic disease of the œsophagus, which had been previously ignored by almost all writers, has received due consideration in every important treatise on syphilis.

Of the two illustrative cases which were first published by Mr. West, the first presented the feature of secondary dilatation above the seat of stricture; and is otherwise so interesting and instructive as to be well worthy of examination in some detail. The patient was a girl, æt. 21, who had for several years suffered from well-marked syphilitic phenomena, such as a scaly cutaneous eruption, sore throat, &c. "She had had gonorrhœa three years ago, but denies having ever had sores or a bubo." At the time of admission into hospital her condition is described as follows:—"She now complains that she cannot swallow anything, and that her food returns during the act of swallowing; about twice a day she is able to swallow without much difficulty. She has no pain, except during deglutition. The throat is very much ulcerated; both tonsils, as well as the fauces and soft palate, being involved; the surface is ash-coloured, with red patches dispersed here and there. She is much emaciated, and very anæmic. Pulse weak; tongue clean; bowels open; urine scanty, but clear and healthy." She was "ordered five grains of iodide of potassium in an ounce of decoction of bark, three times a day, and to use the hydrochloric gargle." Nitrate of silver was afterwards applied to the throat, and mel boracis was used as a gargle.

"This treatment was persevered in till the 28th inst., but without benefit; she got weaker, and the ulceration of the fauces became more extensive, while swallowing was even more difficult; she took scarcely any food, and had no relish for anything. An attempt was made to pass a small œsophageal bougie, but it was ineffectual. . . . Attempts were made every other day to pass a gum-elastic catheter, and, although the stricture could not be penetrated, yet when pressure was made against it for a few minutes, she generally found that she was enabled to swallow better after a few hours." No improvement having occurred from the various forms of treatment which had been adopted, it was determined on the 10th of July to try the effect of a course of mercury, "in spite of her debilitated state, and for some short time, indeed, it seemed to give relief;" a slight amendment was perceived; deglutition was less painful and difficult. On the 6th of August this transient amelioration had ceased. "She had relapsed into her former condition and could not swallow anything for hours together, all attempts at deglutition being attended with the

most painful straining and spasm." She died, exhausted, on the 2nd of September.

On post-mortem examination, it was found that "the upper portion of the œsophagus, for about four inches, was much dilated; its mucous membrane thickened, and marked by spots having the appearance of recent cicatrices. At this distance from the upper end it was suddenly constricted, and terminated in a narrow canal which would barely admit a No. 4 catheter. This constricted portion, which was about two inches and a half in length, was formed by the thickening of the mucous membrane, and by fibrous deposits in the form of bands and bridles, having very much the appearance of an old stricture of the urethra. Below this tract the œsophagus continued perfectly healthy to its termination in the stomach."

In reviewing this case, West thus expresses his grounds for believing that the lesion was of specific origin:—"The fact of stricture of the œsophagus in this case was perfectly patent, and it remains to consider whether any cause, other than that to which I have referred it, can have produced this lesion. Certainly no positive proof of the primary sore can be advanced, but the secondary symptoms extending over a long series of years are distinctly marked; and in how many cases do we find persons in the class of life of this girl denying that they have ever had sores, when their effects are but too plainly visible in the scarred skin, the ulcerated throat, and the carious ossa frontis and tibiæ of the sufferers. Such a sore, no doubt, existed at some period of her career, and its probable site was manifested in the post-mortem examination by a cicatrix in the lower part of the vagina. We have no account of the swallowing of any caustic or irritating fluid, so that we cannot attribute the stricture to that cause. But we find a patient gradually exhibiting the symptoms of well-marked syphilitic cachexia, and also experiencing frequent ulceration of the fauces and pharynx. At first, slight dysphagia alone led to the suspicion that there was narrowing of the œsophageal canal; but, with its persistence and tendency to become worse, the suspicion became augmented, until at last all doubt was removed on an attempt being made to pass a small-sized œsophagus bougie. . . . The presence of numerous recent cicatrices clearly indicated that ulceration had existed in the walls of the œsophagus. The deposit in the submucous tissue was fibrous; it was exactly similar in nature to that which is so well described by Dr. Wilks as characteristic of syphilitic ulceration, and could not under any supposition, be referred either to cancerous or tuberculous degeneration."

In addition to the various causes exemplified by the histories of the cases already given, I would like to call attention to the occurrence of the very rare condition of inflammation of the lining mucous membrane of the gullet as an efficient cause of dilatation. To this, perhaps, as much as, or more than, to the mechanical stretching, may be attributed the origin of the case published by Spengler, in which the patient, during the performance of a hasty meal, had swallowed a hot dumpling, which "stuck fast." According to Zenker, "The view of a primary inflammation is best supported by the case of Stern, where there was an early opportunity for post-mortem examination (a man, twenty years old, who died eight months after the commencement of difficulty in swallowing), and where the microscopical examination of the greatly thickened and hypertrophied mucous membrane, in addition to a partial deficiency in the epithelium, and raising up of the same by pus-cells, discovered a small-celled infiltration through the whole thickness of the mucous membrane, here and there extending down into the muscular layer."

The fact that in cases of inflammation of the lining

membrane of the gullet, the affected part—except when the patient is immediately placed under skilled supervision—is so likely to be further injured by the necessary acts of deglutition, furnishes a prominent factor in the aggravation and prolongation of the inflammatory condition. This may go on till, as occurs in the other hollow viscera, the muscular coats have completely lost their elasticity and contractility, with the inevitable sequel of dilatation—increasing day by day till some mechanical limit has been reached.

In the class of cases in which the modification of structure displays the *saccular* form of dilatation, or, in other words, does not involve the whole circumference of the œsophageal wall, we have the formation of *pouches* or *diverticula*. Such specimens are much more frequently met with than those which I have been hitherto considering. As might be expected, the formation of such pouch or diverticulum is sometimes due to a definite obstruction in the course of the tube, which has the effect of preventing the free passage of the ingesta. The mechanism of the production under such circumstances is easily understood; the food, having been arrested in its downward course, accumulates above the seat of obstruction, and some part of the wall of the canal—weaker or less supported by the surrounding structures than the rest—yields to the continuously applied pressure, just as happens under corresponding circumstances in the rectum and urethra. Some cases have been recorded in which the dilatation of the tube appeared to be the result of the obstruction due to the impaction of a foreign body in the gullet. The most remarkable instance of this kind that I have met with is that recorded by Ludlow ("Medical Observations and Inquiries," Vol. III.), of which the following is a condensed account:—

The patient, a brewer, aged about 60, and reduced to the last degree of emaciation, gave the following history of his own case;—About five years before, he had swallowed a cherry stone, which had stuck in his throat; from which it was expelled three days afterwards during a strong fit of coughing. While the foreign body remained in the pharynx there had been some difficulty of deglutition, the pain which he experienced having been attributed by the patient to the irritation which it had produced in its descent. After its expulsion, he felt for a long time considerable pain in the place where the body had been lodged. About a year after, he began to observe that, an hour or two after a meal, part of the food returned into his mouth unchanged. The quantity which was brought up in this way gradually increased, while the period of time which elapsed between the meal and the occurrence of the regurgitation diminished, till at last the food returned while he was still at table. This now occurred so suddenly, especially when he drank, that he was sometimes nearly suffocated. At last he was unable to swallow more than about four spoonfuls till the aliments returned into the mouth by 'a process similar to that of rumination.' For thirty-six hours before he was seen by Ludlow for the first time, he had been unable to get any nutriment into the stomach. To sustain life under these circumstances, recourse was had to nutrient enemata, but he died thirteen days afterwards in a state of exhaustion.

"On post-mortem examination an immense muscular sac was discovered, lying between the œsophagus and the vertebral column. It was inclined rather to the right of the middle line, and descended into the thorax, but had contracted no adhesions with any of the surrounding structures. A careful dissection showed that this pouch was formed by a dilatation of the posterior part of the pharynx, but the thickness and the structure of the pouch and of the pharynx corresponded so exactly, that it was impossible to say

where the dilatation exactly began. The wall of the œsophagus was very much thinned where it lay in contact with the sac, and the opening by which it communicated with the pharynx was very much narrowed."

In his remarks on this case, Ludlow had no hesitation in expressing his belief that the presence of the cherry stone was the starting-point from which the formation of the sac proceeded. He supposed that, having become arrested in the mucous membrane of the pharynx, and being successively pressed upon by the descending bolus in each act of deglutition, it had at last formed for itself a cavity more or less adapted to its size, and which remained when the stone was rejected, and went on increasing by the presence of the ingesta which remained lodged within it. Nevertheless, the real explanation of the origin of the pouch in this case must still be allowed to remain an open question; and it must continue to be a matter of uncertainty whether the theory of Ludlow be the true one, or whether, indeed, the pharyngeal wall was not the seat of a congenital malformation, slight at first, but gradually increasing in size by the pressure of retained aliments which were there arrested in their descent. The present writer has great difficulty in conceiving how even a cherry-stone could be so retained in a pharynx of normal form during a period of several days. It should, however, be added that, among others, the great pathologist, Rokitsansky, sanctions the hypothesis advanced by Ludlow.

Another very remarkable case of pharyngo-œsophageal pouch has been described by Gianella (cited by Mondière, *Archiv. Gen. de Méd.* XXIV., 411). The patient in this case died at the age of sixty in a state of extreme emaciation, the result of dysphagia; from which he had suffered in a less degree from his youth, but which had for some time before death become so much aggravated that no nutriment could be got into the stomach. Before it took on this severe form he had been able to get down his food by eating slowly, and aiding the descent of each morsel by making pressure on the front of the neck with his hand. At the autopsy, the superior opening of the œsophagus was found narrowed; and, lying between that tube and the vertebral column, a pouch was found extending downwards for a distance of six or seven fingers' breadth. The widest part of this pouch was the opening by which it communicated with the œsophagus. In commenting on the clinical features of this case the writer observes that: "As soon as the aliments arrived at the constricted portion of the œsophagus, instead of following the natural route they descended into this pouch, in which they remained till rejected by a spasmodic contraction of its walls."

A remarkable case of pharyngo-œsophageal pouch has been recorded by Hankel. The patient was a merchant, æt. 54, who died of inanition, the ultimate result of dysphagia which had commenced nine years before:—

"He had on one occasion perceived, while eating, that the morsel was suddenly arrested in the œsophagus. From that time he had always suffered from pain in swallowing. This went on increasing; a portion of the food was rejected after each meal; he was obliged to re-chew it in order to swallow. After a meal, there was always found on each side of the larynx a large tumour, which could be emptied of its contents by pressure; a part passing downwards into the stomach, and a part returning into the mouth.

"On examining the œsophagus after death, a diverticulum of considerable size was found springing from its upper extremity, just beneath the inferior fibres of the pharyngeal constrictor. The opening by which it communicated with the œsophagus was of smaller dimensions than the tube itself; the sac was three inches and nine lines in length, and one

inch and nine lines in breadth; its walls, which were of considerable thickness, were formed by the tunics of the œsophagus: the mucous coat was atrophied."

As Hankel observes, the sac in this case being soon filled by the ingesta at each meal, and having the strong resisting surface of the vertebral column to support it on the posterior aspect, exerted increasing pressure on the œsophagus from behind, till it came by degrees to close it so effectually as to entirely prevent any further passage of food along the tube.

Another very similar case has been placed on record by Coffin (*Bull. de la Soc. Anat.*, 1847). The cause of the dysphagia had remained unexplained during the patient's life. After death a pouch was found springing from the œsophageal wall at its upper end.

A specimen was exhibited to the Pathological Society of London (February 21, 1848) by Mr. H. C. Johnson, in which a pouch large enough to hold a small orange was found to be connected with the œsophagus on its posterior aspect, and on a level with the lower border of the cricoid cartilage. The patient had suffered from dysphagia, for which no cause could be assigned, and about two hours after each meal a considerable portion of the food was ejected in the form of pellets. These had probably been formed in the pouch by the motions caused by the contractions of the tube.

(To be concluded in our next.)

CLINICAL NOTES OF FOUR CASES OF CHRONIC PROSTATITIS. (a)

By DR. H. DELAGRAMMATICA.

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YOU are all aware of the part played by the prostate in cases of inflammation of the genito-urinary organs, especially in cases of blennorrhagia. It is indeed in this gland that we most frequently find the characteristic symptoms of suspected urinary tuberculosis, the cause of the persistence and tenacity of chronic urethritis, and of the various urinary disorders, from simple difficulty of micturition to complete retention of the urine, with its formidable results both immediate and future. According to some authorities it is also the source of troubles of a psychopathic nature, and it is acute inflammation of this organ which, complicating an acute or chronic blennorrhagia, aggravates an otherwise favourable prognosis to such an extent that it may even threaten the life of the patient.

There are very few organs in the human body as vascular as the prostate and as well supplied with lymphatics; and if we bear in mind the numerous anastomoses of its venous plexus, with the hæmorrhoidal, spermatic and vesical plexuses, and especially the plexus of Santorini in front, and the facility with which active congestion or venous stasis may take place in the pelvic organs, we shall readily understand why this gland is so prone to congestion. Its direct connection with the rectum, and more especially with the posterior urethra, renders it, already vulnerable by reason of its anatomical structure, an easy prey to the micro-organisms which flourish in these regions.

It is not surprising, therefore, that a great, possibly an exaggerated, importance should have been accorded to the part it plays in urinary pathogenesis. As late as the end of the last century this gland was thought to be the exclusive seat of blennorrhagia. This error is accounted for by the fact that as gonorrhœal urethritis never causes death

so long as it is free from complications, and because in the fatal cases one occasionally discovered an abscess of the prostate, which had been the starting-point of a diffuse pelvic suppuration. The phlegmon, to which the patient had succumbed, however, was not due to the primary lesion, but to the complication of an urethritis, which had passed unnoticed or had been erroneously regarded as of secondary importance, though, as we now know, it was the initial lesion.

We no longer look upon the prostate as the indispensable and inexhaustible reservoir of the gonorrhœal discharge. Some authors, aware of this fact, have fallen into the opposite error, and hold that this gland, when chronically inflamed, gives rise to the most varied psychical disorders. Quite recently, for instance, Dr. Guizis, of Athens, describes hysterogenic points which he professes to have discovered in the prostate and bladder. Though there may be a few cases of chronic prostatitis, associated with symptoms of neurasthenia or hysteria, there exist a much larger number of cases of prostatitis, which do not exhibit any nervous symptoms, as was the case with the eight patients under my own observation. Besides, if this were true, why should it not hold good for other chronic affections of the prostate?

This is certainly not the case in hypertrophy of the prostate, for example, because this only manifests itself at an advanced age, when psychical troubles are rarely met with. It is much more probable that these neuroses, when they exist coincidentally with a chronic inflammation of the prostate, are quite independent of this inflammation, and it is highly improbable that it alone causes the dreaded genital impotency.

Having disposed of these aspects, chronic prostatitis is none the less a serious disease, not so much in itself as in its being a possible source of auto-infection which may lead to spermato-cystitis, to epididymitis and to cystitis, the consequences whereof must be difficult to foretell, favouring as it does the persistence of the chronic urethritis and consequently introducing a source of contamination, should the purulent secretion contain the gonococcus.

For these reasons and also by reason of the fact that chronic prostatitis is far more frequent than is generally supposed, it occurred to me that a detailed account of four cases out of eight I have recently had under my observation would prove instructive, each of them presenting special points of interest.

CASE I.—P. N. M., at. 40, contracted gonorrhœa at the age of 26. This did not entirely disappear, and two years later he married and infected his wife. From that time they have mutually contaminated each other with gonococci, constantly rejuvenated, so that both of them still suffer from the complaint.

Two years ago the patient experienced difficulty in passing water and consulted a doctor, who, having diagnosed a stricture of the urethra, dilated it to No. 18 (French scale). The resulting irritation caused a slight increase of the running, which once again became yellow. The doctor adopted a combined treatment of alternate irrigations and instillations of nitrate of silver solution. After a few days of this the patient developed acute cystitis with pyuria and hæmaturia, and intense vesical tenesmus. The patient remained in bed for a month, and the cystitis was not cured for at least five months. During this time the patient complained of pains over the left kidney.

Five months ago the patient came to see me; he was pale, feeble, and very anxious about his condition. He passed urine five times a day, but did not get up during the night.

I obtained two samples of urine, the first was muddy and contained grumous material; the second was clear. I filled the bladder with a boracic solution, and on

digital examination, per rectum, I found the prostate, if anything, rather small, flabby, and yielding, showing a slight depression about the middle, without any other anomaly or inequality of consistence. The germinal vesicles were unaffected. I massaged the prostate and again collected a sample of urine. At the bottom of the glass in which I had collected the boracic acid solution numerous whitish corpuscles were to be seen. There was a slight constriction in the bulbo-perineal urethra, and when I reached the prostatic part of the urethra, I was unable to get the bougie any further, the instrument striking an obstacle which was only surmounted by the aid of the finger *per anum*.

Microscopical examination of the grumous material obtained by massage of the prostate gave the following results:—Numerous squamous epithelial cells, leucocytes in abundance; fine refractile granules, and large cocci, probably staphylococci; no gonococci. With these data, diagnosis was easy, viz., stricture of the urethra with posterior urethritis and chronic prostatitis of old standing. By way of treatment I dilated every other day, following this by massage of the prostate and irrigations with perchloride of mercury (1:20,000). After a month's treatment the urethra was dilated to No. 28 of Charrière's plate, and the massaged prostate no longer yielded any secretion.

In order to control the result, and in order also to obtain a more marked action on the posterior urethra, I gave three instillations of perchloride of mercury (1:3,000). After the last instillation, in spite of the violent reaction, the urine obtained on the following day was clear, and further massage of the prostate gave no result. The patient may now be looked upon as cured, but it will certainly not be long before he is reinfected, because his wife persistently refuses to undergo medical treatment.

CASE II.—P. P., at. 38, butcher. Had his first attack of blennorrhagia three years ago, which was cured in two months. He had a second attack eighteen months ago, since which he has suffered from gleet. During the second attack the patient developed a right epididymitis, and suffered from frequent micturition.

The patient consulted me about his gleet (having previously been under the care of several other doctors), which, in spite of the most varied and the most energetic treatment, had not disappeared. He also complained of spermatorrhœa.

The urethra was inflamed, but the bougie (No. 28) was passed without difficulty. On withdrawing the instrument it was covered with a viscid, dirty-yellow material mixed with blood.

Digital examination per rectum revealed an enlarged, not very hard, renitent prostate without any inequality of surface, and insensitive to pressure. I massaged it, and expressed a viscid muco-purulent material, which escaped from the meatus. Thereafter the prostate diminished in size and became flatter.

The pus obtained from the prostate was examined microscopically, and found to contain leucocytes, with a few rounded pavement-like epithelial cells, bacilli and gonococci. My diagnosis in this case was: Chronic prostatitis, or, rather, an abscess in the prostate with general urethritis.

I therefore adopted the treatment of irrigations with potassium permanganate, as well as massage of the prostate. The flow, however, continued for another week, and although the prostate was regularly emptied, it was found full at subsequent examinations. Believing that there was a cavity in the prostate, I tried, by means of straight and bent india rubber sounds, to enter it, but my efforts failed, so I forced the fluid into the cavity of the prostate by pressing on the urethra, and thus interrupting the escape of the fluid while the patient was voiding

the liquid which I had injected into his bladder. This method proved to a certain extent successful, for it brought away some grumous material.

The prostate was subjected to this treatment for twenty days, when it was found to have greatly diminished in volume, but massage continued to express whitish material, which on microscopic examination was found not to contain any gonococci. Irrigation with perchloride of mercury solution failed to arrest the suppuration.

CASE III.—H. K., at. 30, had syphilis three years ago, his first attack of blennorrhagia thirteen years ago, lasting two months; the second attack of blennorrhagia was contracted five years later and lasted four months; a third blennorrhagia five years ago was allowed to cure itself. He had a fourth attack two years ago, followed by gleet, which has persisted ever since. It is highly probable that the patient did not thoroughly recover from the second attack of blennorrhagia, and that the subsequent attacks were recrudescences. The doctor who treated his second attack had already discovered a stricture which only admitted a filiform bougie, and he only partially dilated it. An attack of cystitis complicated by orchitis was the result of this treatment.

The patient complained that for some time past he had had seminal losses mixed with blood. The discharge was most copious when he passed a motion. The meatus was narrow, barely admitting a No. 20 bougie, so I performed meatotomy. The patient passed water drop by drop, and the difficulty of micturition had become more marked since the previous day, when Dr. Mally, of the Austrian Hospital, urgently advised urethotomy.

The urine was very turbid and had an ammoniacal odour; the bladder reached to within a finger's breadth of the umbilicus. In spite of this, micturition was neither frequent nor urgent. The patient passed urine three or four times a day, and never during the night. After several attempts I managed to introduce a No. 4 filiform bougie into the urethra, and leaving it there I advised the patient to pass urine without removing the bougie.

Per rectum the prostate was felt to be of enormous size, and I was quite unable with my finger to make out its limits. Its right lobe was bigger than its left, and it was soft, yielding, and smooth, and did not exhibit any inequality of surface or differences in consistency. Even marked pressure upon it did not give rise to the slightest pain.

The diagnosis was obviously easy, strictures of the urethra (they were multiple, as subsequent examination proved) with chronic prostatitis and also mild chronic cystitis.

Microscopical examination of the urine showed a large number of leucocytes, squamous epithelial cells more or less degenerated; no gonococci, but, on the other hand, numerous bacilli, probably coli bacilli. Subsequent microscopical examination of the urine showed cylindrical epithelial cells and large hammer-shaped casts; these latter, said to be characteristic of follicular prostatitis, besides being indeed casts of the prostate glands. The treatment used was the same as in the first case, and consisted, first, in dilatation, and, when I had arrived at a fairly high number, I washed out the bladder with silver nitrate solution 1-1000, which promptly cured the cystitis.

At the same time I massaged the prostate, and this was followed by the evacuation, *via* the urethra of a large quantity of a sticky fetid pus with a strong odour of ammonia. As the dilatation proceeded, I was enabled to make out three distinct rings in the penile urethra, and an obstruction in the perineal region. I pushed the dilatation, according to the rules laid down by Guyon, to No. 27 without causing any bleeding.

After several examinations I arrived at the conclusion that the prostate of this patient was one large cavity, which fact led me to think of tuberculosis, and consequently to search for the specific bacillus, which, however, was not found. After two months' treatment the prostatitis diminished to half its original volume, the stream of urine became large, and the bladder, the capacity whereof when first seen was 500 grammes, returned to normal, and the urine was clear. I should have liked to continue massage of the prostate simultaneously with the other general methods prescribed, but the patient, after forty-five days' treatment, passed urine with ease, and as it was once more clear, he thought himself cured and did not return.

CASE IV.—L. P., at. 46, has had several mild attacks of blennorrhagia since the age of 20. He had not suffered from cystitis or orchitis until fifteen years ago. About this time the patient had a fall on the perineum, which was followed by hæmaturia, but there was neither retention nor extravasation of urine as the result of this accident.

Owing to the prompt cessation of the hæmaturia, the patient did not at first consult a doctor, but a week later he altered his mind and went to a specialist, who passed a catheter and set up an acute cystitis, which took two months to cure, and then incompletely, since the urine still remained very cloudy. Curiously enough, the same accident happened to the patient again three years later. He was climbing a ladder, and he fell athwart one of the rungs. This was immediately followed by hæmaturia, less copious, however, than the first, and again there was no retention or extravasation of the urine to the bruised region. Frightened by his previous experience, he carefully avoided consulting a doctor. Several months after the accident he began to complain of difficulty of micturition, and along with this the cystitis recurred. Micturition became frequent and urgent, and there was terminal hæmaturia and very turbid urine.

On exploring the urethra, a membranous spasm was distinctly felt, and a No. 24 bougie *à boule* was passed as far as the prostatic region, but no farther. I took a bent gum elastic bougie of the same calibre and passed it into the bladder. A No. 16 straight bougie could not be got in farther than the prostatic region, and it was only by raising it with the aid of the finger in the rectum, that it became possible to pass it into the bladder. There was scarcely any prostate, and I could feel the bougie travelling over the tip of my finger quite readily, through the much thinned walls of the prostate.

Massage of the prostate, after washing out the bladder with boracic acid solution, caused the expulsion of much grumous material.

The patient complained of pain in the region of the left kidney, adding that several months previously he had been very feverish coincidently with each fresh attack of this pain, and this had been followed by the passage of a very purulent urine.

Microscopical examination showed the presence of epithelial cells from the bladder, of leucocytes, and of bacilli exhibiting the characteristic form and colour of coli bacilli.

The patient is still under observation, an intercurrent affection having prevented him from following the prescribed treatment. I propose to perform cystoscopy if the urine after the treatment directed to the relief of the cystitis does not clear up, to find out whether the pus comes from the ureters.

The most interesting point is the collapse of the prostate almost in its entirety, this having taken place insidiously, without any inflammatory reaction, and the resulting deformity of the canal.

Clinical Records.

CASE OF RADICAL CURE OF HERNIA.

By PERCY G. LODGE,
Bradford, Yorks.

MR. T., *æt.* 40, architect, of Leeds, had a swelling as large as an ordinary orange in left inguinal region, the testicle undescended on the same side. His doctor, Dr. Higgins, recommended operation. The duration of the epiplocele was about six years.

On October 15th, at patient's house, the preparations being already completed beforehand, I made an incision of four inches afterwards increasing it to eight, over the swelling. The various layers were carefully picked up and divided on a director until the sac was reached and carefully opened. Only omentum adherent at various points was exposed within. These were gently separated and an attempt made at its return within the body, this, however, proved impossible, so we decided on its removal. The omentum was opened out and snipped across with blunt-pointed scissors, catching up the vessels with catch forceps as each was divided. The weight of omentum thus removed was over one pound and a half. The forceps were now tied off and the free edge hemmed with a running catgut suture. Finally, the stump was returned. The front wall of the canal during this time was lying open. The next step taken was to examine the testicle; it was dissected up with the sac, and its removal was now seen to be necessary; it was very soft and much atrophied. Accordingly the cord and sac were divided at just below the level of the internal ring, the vessels in the stump were tied, the sac previously separated was closed by ligature and stitched to the stump. The muscular structures of the abdominal wall were now securely stitched to Poupart's ligament so as entirely to close in the abdominal wall. A continuous suture closed up the sponeurosis of the external oblique, and there only remained a few sutures for the skin. Afterwards suitable dressings were applied, and the limb immobilised by a piece of stout poro-plastic felt down the front of the body and thigh. Dr. Higgins tells me that the further progress of the case was for the most part uneventful, beyond one or two stitch-abscesses at the lowest part of the incision, which eventually did well. The cure is most complete. The patient is now well and able to get about quite easily. My thanks are due to Drs. Crowther and Higgins for their valuable assistance.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, FEBRUARY 23RD, 1900.

DR. LEONARD SEDGWICK, Vice-President, in the Chair.

CLINICAL EVENING.

PRIMARY TUBERCULOSIS OF THE NASAL SEPTUM.

DR. ST. CLAIR THOMSON presented a young woman who had already been shown to the Society in October, 1897. In July, 1896, a growth the size of a filbert was removed from the right side of the nasal septum, diagnosed as tuberculous though no bacilli were present. Three months later the base of the growth broke through the septum. She had active local treatment and three injections of Koch's tuberculin, to which she reacted. When recently examined it was seen that the perforation had increased in size, but the condition in other respects was better. Sections showed giant cells and caseation but no bacilli. The treatment was painting with Mandl's solution of iodine and iodide of potassium, and, later on, guaiacol and olive oil.

MR. BARKER referred to a case of very extensive tuberculosis of the nose which had involved the lacrymal sac and had perforated the soft palate. Treatment by painting with the perchloride of iron and dusting with iodoform had proved very successful.

DR. KIDD agreed that the lesion was probably tuberculous, although the microscopical appearances were not conclusive.

A CASE OF LATERAL CURVATURE OF THE SPINE IN AN INFANT.

MR. JACKSON CLARKE showed an infant, *æt.* 17 months, with well-marked scoliosis, probably due to rickets. Deformity was first observed at 13 months. In addition to ordinary general treatment he insisted upon the importance of daily manipulations and the use of an effective instrument, such as Chance's splint, and he pointed out that poroplastic and other corsets and recumbency caused loss of muscular strength and general physiological depression, and were therefore to be avoided.

OPERATION FOR IRREDUCIBLE TRAUMATIC DISLOCATION OF THE KNEE.

MR. BATTLE showed a woman, *æt.* 50, who, as the result of a severe twist of the left knee, had marked displacement of the knee-joint, the patella being displaced outwards and fixed. The mobility of the joint pointed to rupture of the internal lateral and crucial ligaments. Manipulations having failed he opened the joint by a transverse incision, dividing the ligamentum patellæ. The patella was found to be fixed by a thick muscular band, torn from the inner condyle, through which it had slipped, and it was freed and replaced. On opening the joint freely the anterior crucial ligament was seen to be torn away from the femur, and the posterior crucial ligament lacerated. These were sutured and the internal lateral ligament repaired. The case did well except for a little suppuration on the inner side of the wound, and the patient could now walk normally.

A CASE OF ACHONDROPLASIA.

MR. KELLOCK showed a boy, *æt.* 4½ years, the second of a family of four, the other children being normal. Was born easily at term, but had a queer shape. Breast-fed until ten months. Began to crawl at six months, but did not walk until two years. Was only 30½ inches in height, the deficiency bearing on the lower limbs, the bones whereof were shorter than usual, and the epiphyses abnormally large. The head had a large vault and a narrow base, and the patient presented the usual lordosis, prominent abdomen, genu retrorsum, waddling gait, and a peculiar manner of raising himself, all features characteristic of such cases. The child was intelligent, and had good general health.

TWO CASES OF CONGENITAL DEFORMITY OF HANDS (FATHER AND SON).

DR. CHAPMAN showed father and son presenting a peculiar deformity of the hands, with, in the child, absence of radius. The right hand of the father exhibited the peculiarity in respect of the three phalanges that the second was flexed at a right angle on the first and the third on the second. The thenar eminence was almost entirely absent and abduction and adduction non-existent. In the left hand the terminal portion, representing the thumb, was united for two-thirds of its extent with the index finger, and there was a wide cleft between the first and second fingers. The man used the index finger like a thumb and the hand could be used for most purposes. The son, an intelligent boy of three, exhibited the following deformities:—On the right the thumb at its terminal part resembled a finger. It had three phalanges, the second and third being permanently flexed on the first. On the left there was an entire absence of the radius with a club hand of the radiopalmar variety.

A CASE OF ASTHENIC BULBAR PARALYSIS.

DR. GUTHRIE showed a girl, *æt.* 23, formerly a waitress, working very long hours. Two years ago she noticed some difficulty in articulation, worse when fatigued. Last July swallowing began to be difficult for both solids and liquids, and then she became unable to close her eyes properly. These symptoms had gradually increased until first seen a month ago, when there was weakness of the orbicular muscles of the eyes and mouth and of the soft palate. He regarded it as a case of the

kind described by Strumpel as asthenic bulbar paralysis. The condition had improved under rest and treatment.

CASE OF PARALYSIS OF CRANIAL NERVES.

Dr. BEEVOR showed a case of "Paralysis of the 7th, 8th, 9th, 10th, and 11th Cranial Nerves on the Left side," in a woman, *æt.* 32. No family history. Six years ago she contracted a primary specific sore, followed by sore throat, hair falling off, and rash over chest. Since then had two children, one born blind, the other became so soon, and a miscarriage. Nine years ago blow on the left ear, with deafness and noises ever since. *Present Illness.*—Two-and-a-half years attended for twitching of left side of tongue and the facial paralysis and deafness in the ear. Three months neuralgic pains in left temple. Six weeks voice hoarse and difficulty in swallowing. Three weeks discharge of blood from left ear. *At present.*—Right optic neuritis, not complete. Absolute deafness of the left ear to aerial and osseous conduction. Polypus Taste lost front and back, on left side of tongue. Left facial completely paralysed, including platysma. Paralysis of palate on left side, so that would draw to right on phonation and also on reflex stimulation. Difficulty in swallowing. On posterior wall of pharynx left side, some anæsthesia. Complete paralysis of left inferior laryngeal nerve, with the left vocal cord in the cadaveric position. Pulse frequency not increased. Tongue, left side wasted with fibrillar tremor, goes to left when protruded, cannot put tip so well into left as right cheek. Left sterno-mastoid, complete atrophy and paralysis. Left trapezius atrophied and paralysed with exception of fibres, arising from sixth cervical to second dorsal spines, which contract faintly to volition and faradism. Rest of muscles do not react to faradism. Sterno-hyoid and omo-hyoid contract well. Severe neuralgic pain in the ear and temple. Probably syphilitic meningitis affecting nerves of medulla.

A CASE OF UNILATERAL LESION OF THE PONS.

Dr. COLLIER, for Dr. Hughlings Jackson, showed a man, *æt.* 40, with no pathological history, whose illness began gradually with giddiness, deafness of left ear, alteration of speech, difficulty in guiding left arm and diplopia, difficulty of swallowing and mastication, and loss of feeling on the left side of the face. No headache, vomiting or dysuria. The optic discs were pale, and there was paralysis of the fifth, sixth, seventh, and eighth cranial nerves on the left side, with weakness of the ninth, tenth, and eleventh. He held his head in the right cerebellar position. There was slight spasticity of the right arm and leg, and the speech resembled that often met with in cases of disseminated sclerosis.

CASE OF MACROGLOSSIA AFTER TWO OPERATIONS.

Mr. BARKER showed a girl who first came to him thirteen years ago with macroglossia, when he removed wedge-shaped portion of the organ bringing the side angles together. The case is recorded in Vol. 41 of the *Pathological Transactions*. She had returned last year with recurrence, and the growth this time being in the direction of the hard palate, and on this occasion he had removed a wedge-shaped piece in a horizontal plane, bringing the upper and lower flaps together. Sections of the first growth showed a preponderance of lymphoangiomatous tissue, but the latter was more of a nevoid character.

THREE SURGICAL CASES.

Mr. F. C. WALLIS showed a child, *æt.* 3, with tuberculous disease of the knee which he had treated by division of the patella, free exposure of the joint, removal of the affected synovial membrane and swabbing with pure carbolic. The child is now able to walk, and has limited movement of the joint. He referred to two other cases similarly treated with equally good results.

He also showed a case of acute infective osteomyelitis in a child, *æt.* 12, with necrosis of the whole of the shaft of the humerus. A large sequestrum was removed (shown). The arm, which was previously useless, is now rapidly regaining power.

Case 3 was one of osteitis and periosteitis in a child, *æt.* 11, which he treated by cutting down on the tibia,

elevating the periosteum, and cutting a deep groove through both the epiphysis and the diaphyses. Since the operation the pain had disappeared and the child could stand. The case was originally thought to be tuberculous.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF MEDICINE.

MEETING HELD FRIDAY, JANUARY 26TH, 1900.

The President, Dr. J. W. MOORE, in the Chair.

Dr. R. TRAVERS SMITH exhibited a case of ataxic paraplegia and a case of amyotrophic lateral sclerosis.

BRONCHOTOMY IN CROUP: DIPHTHERIA AND ALLIED MEDICAL CONDITIONS.

Mr. H. GRAY CROLY detailed the symptoms of a case of diphtheritic inflammation of the larynx and trachea in a child, *æt.* 2, admitted recently into the City of Dublin Hospital under the care of Sir George Duffey, senior physician to the hospital. The child at 10 p.m. was in a most critical condition—urgent dyspnoea, lips bluish, signs of collapse. With much difficulty the fauces were examined. The tonsils were considerably swollen, and there was some evidence of a whitish patch on one side. High tracheotomy was performed; the child got immediate relief, and fell into a peaceful sleep. At 4 o'clock a.m. the little patient became very restless, gradually got worse, and died within twelve hours of the operation. The larynx and trachea were removed in a few hours, but no further examination was made. The larynx and trachea, with the silver tube *in situ*, were exhibited. The epiglottis was thickened and hard; the folds at the entrance of the larynx considerably thickened. On opening the windpipe a bluish false membrane easily detached was found at one side. Mr. Croly exhibited some fine specimens of membranous croup from the Museum of the Royal College of Surgeons. He also showed some trachea tubes, and made some practical suggestions on the shape of the tube with a view of preventing irritation, and advocated strongly the high operation, which is so much easier and safer than the deep operation.

The PRESIDENT said there were three affections of the larynx attended with evidence of obstruction to the breathing. First, laryngismus stridulus, a purely spasmodic affection. Then, a very rare condition, croupous laryngitis, analogous to croupous or plastic bronchitis. To the third condition, diphtheria of the larynx, they must refer most of the cases formerly described as croup. His experience was that two micro-organisms were concerned in the production of diphtheria—namely, the Klebs-Löffler bacillus and the streptococcus; and in some recent cases in the Meath Hospital of what was undoubtedly diphtheria, the former micro-organism was conspicuous by its absence. That these were diphtheria, and of a malignant type, was proved by the fact that there were three fatal cases out of six. Four of these cases were examined bacteriologically, but in not one was there a culture of the Klebs-Löffler bacillus obtained, but in two of them Oertel's streptococcus was found. He presumed that what Trousseau meant by malignant diphtheria was diphtheria after the development of the constitutional symptoms as distinguished from the merely local disease.

Dr. E. H. TAYLOR did not agree with Treves' statement that there was no danger in cutting the isthmus, for on injecting the gland large vessels were found crossing in the isthmus.

Professor E. H. BENNETT did not concur in Mr. Croly's recommendation of taking out a piece of the trachea, because he knew of a man of great skill, now dead, who in taking out a piece of the trachea took out a portion of the innominate artery. He preferred a straight simple incision in the middle line.

Dr. O'CARROLL gave an analysis of cases in the Hardwicke Hospital. They had 101 cases labelled diphtheria in the last year. In 47 of these the Klebs-Löffler bacillus

was found, in 46 it was not identified, and in the remaining 8 cases, for some reason or other, no examination was made. There were 17 tracheotomies done, with 11 deaths and 6 recoveries. The cases below two years of age were not successful when operated on, this fact bearing out Mr. Croly's observation. Dyspnea in long-standing cases was due to the development of bronchopneumonia and obstruction of the smaller tubes. Only one or two of those cases in which no Klebs-Löffler bacillus was found died, and they were cases of malignant local gangrenous sore throat, possibly diphtheritic or post-diphtheritic. In those, also, there were other infections, streptococcus and straphylococcus. Tracheotomy was useful in giving the patient a longer time to avail himself of the ordinary aids to recovery. In the Hardwicke Hospital they were fond of large doses of the antitoxin, giving to patients three years old at least 3,000 units. Calomel fumigations and swabbing out of the throat locally are also adopted.

Dr. PARSONS said that the expression "membranous croup" was a most unfortunate one, as they did not know exactly what the older writers meant by it. It seemed to him a pity to place the cases in the Meath Hospital, in which no Klebs-Löffler bacillus was found, under the name of diphtheria. The term diphtheria should be limited to Klebs-Löffler cases, for if they included under this heading every disease with a false membrane, they would not be able to compare results. He took it that the anti-diphtheria serum was useless in streptococcus cases, for what they wanted then was anti-streptococcus serum, which had not yet been proved satisfactory. There was nothing to be learned from past records of surgery since they did not know exactly what disease was meant, and also there was no antitoxin to use then.

Sir George Duffey, Dr. Knott, and Mr. G. J. Johnston also spoke, and Mr. Croly replied.

The Section then adjourned.

THE BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY.

MEETING HELD AT NO. 20, HANOVER SQUARE, THURSDAY, JANUARY 26TH, 1900.

DR. IVOR MURRAY (Scarborough), President, in the Chair.

THE TREATMENT OF DISEASES OF THE NERVOUS SYSTEM AND NERVOUS AFFECTIONS BY BATHS AND CLIMATE.

In opening a discussion on this subject, Dr. HARRY CAMPBELL remarked upon the beneficial influence of change of air which he connected with the wandering habits of primitive man. The open-air treatment he contended was beneficial in other diseases than phthisis, notably in nervous diseases. He referred to the large part which toxins play in neuropathology, and to the potent influence of climate and baths on metabolism, and therefore on the toxicity of the blood. It was often advisable to put nervous patients through a preliminary treatment before sending them away, otherwise they might not benefit by the change. Dr. Campbell held that British Health Resorts were not so well equipped for the treatment of neurasthenia as some of the Continental ones. He referred to the advantage of reducing high arterial tension in some nervous affections, and concluded by inviting discussion regarding the climatic and balneological treatment of sleeplessness, neuralgia, Graves' disease, epilepsy, chronic alcoholism, and morphinomania.

Dr. SYMES THOMPSON spoke of the importance of change of environment in functional and organic nervous diseases. Besides alteration of climate, diet, avocation, &c., we could secure at our spas and health resorts the watchful supervision of trained physicians, with special experience in the application of mineral waters, baths, hydropathic methods, diet, and exercise. He contrasted the effects of Alpine health resorts for those capable of enjoying vigorous exercise with Egypt for persons with organic diseases for whom the restful life on the Nile was often strikingly beneficial.

Dr. RISIEN RUSSELL, in illustration of the good to be obtained from baths in the treatment of chronic organic affections of the nervous system, instanced their ameliorating effect on certain troublesome symptoms in certain diseases of the spinal cord. Peripheral neuritis was chosen to exemplify the beneficial effects of this mode of treatment in certain acute affections of the nervous system, but he insisted on the deleterious consequences to be expected from the indiscriminate use of baths in many acute organic diseases. On turning to the consideration of functional affections, neurasthenia was selected as an example of an affection, the different varieties of which called for very different forms of bath treatment. The neurasthenic who requires stimulating may derive much good from the cold bath properly given while another class of neurasthenic may be injuriously affected by this measure, and may, nevertheless, obtain benefit from the indifferent bath. In conclusion, he alluded to the advantage of baths as a means of administering general faradism or galvanism, and referred to the different effects produced by the two forms of bath.

Dr. KINGSCOTE remarked that high altitudes tend to a high tension pulse, and are therefore unsuitable to hyperæsthetic conditions such as neuralgia and inflammatory states whereas anæsthetic conditions benefit largely, always provided that the heart be sound. For instance, severe neuralgia often subsides immediately on the patient seeking a lower level, whereas the pains due to atrophied muscles often disappear equally quickly on seeking a higher level. Further, toxicity is apt to be reduced owing to increased elimination at high elevations.

Dr. BEZLY THORNE agreed that auto-intoxication exercises a dominant influence in the causation of the greater part of nerve diseases. The "bracing" quality of a climate, he urged, depended more upon the hygrometric condition of the atmosphere than on its mere temperature. A moderate altitude in an open situation, as at Malvern, Buxton, and in parts of Yorkshire, may be far richer in health-restoring conditions than an Alpine height of, say, 3,000 ft., surrounded by mountains. The influence of climate and baths on insomnia depended, he thought, on whether they raised or lowered intra-arterial pressure. In certain cases in which baths increased arterial tension insomnia was aggravated and *vice versa*. Grave's disease being mainly the result of auto-intoxication, suitably administered baths exercised a powerful influence for good. Their good effects in epilepsy are likewise very striking.

Dr. KARL GRUBE, of Neuenahr, said that he had often been struck by the small attention that had been paid in England to the balneological treatment of nervous diseases. Neither in the handbooks on nervous diseases nor in the books of balneotherapeutics sufficient mention is made of this valuable form of treatment. This to him seemed all the more remarkable as some forms of nervous diseases which are particularly benefited by bath treatment appeared to be very frequent in this country—for instance, neuritis. Baths were very effective in the treatment of neuritis, especially when there was much pain. Neither very hot nor cold baths seem to do much good in nervous diseases; on the contrary they very often do harm. Indifferent baths, *i.e.*, baths of a temperature of about blood heat, are most beneficial.

Dr. FLETCHER BEACH said that two cases, one of lateral sclerosis and one of tabes, which had been under his care had been much benefited by residence at the sea-side. Open-air treatment was especially desirable for mental as well as for nervous diseases, and in all asylums patients were given as much open air as possible. In some cases of neurasthenia rest was desirable. The absence of a complete system of baths attached to hospitals was a defect.

Dr. FORTESCUE FOX (Strathpeffer Spa) remarked that baths were of advantage, not in advanced disease (sclerosis) but in the early stages of such disease, and in many nervous disorders, especially those manifested by irritability and exhaustion. A sedative climate and sedative baths, such as those of Schlangenbad, &c., at or a little below blood heat, were valuable in such cases. He also referred to the good effect of douche and peat

baths in peripheral neuritis and in non-inflammatory sciatica.

Dr. LEON (Sidmouth) remarked that, with regard to the effect of climate, high altitude and a dry bracing air had a vaso-constrictor influence; the opposite applied to a low-lying humid situation, arterioles were dilated and the blood pressure low. Sleeplessness was common at high altitudes, and vasodilator drugs also gave good results in sleeplessness and restlessness of old age. With regard to bath treatment, valuable results were obtained in the treatment of local neuralgia, various post-influenzal neuroses, *e.g.*, tachycardia. Sciatica was often much relieved by douches. In the treatment of neurasthenia, change was an important aid, the over-worked should be given rest; the neurotic and invalid never well enough to go out should be stimulated by baths suitably graduated with massage and exercises, and could often be induced to throw off the neurasthenic habit.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, February 24th, 1900.

THE MEASLES MORTALITY IN PARIS.

At the meeting of the Académie de Médecine. M. Vallin read a paper in which he drew attention to the progressive increase in the number of deaths caused by measles in Paris. Statistics showed that measles at present was the most deadly of all infectious maladies. Whilst the number of deaths due to typhoid fever, diphtheria, whooping-cough, scarlatina, &c., was declining for the last five years that of the victims of measles was constantly increasing. That difference might be attributed to great attention to disinfection of those diseases of which the declaration was obligatory. If measles was not inscribed among these maladies, it was because it was believed that the virulence of the morbid germ being transitory, disinfection was applied too late to be of any use. But it should be observed that the contagion of measles did not lose its virulence as quickly as it was supposed, and, on the other hand, the patient did not die of the measles itself, but nearly always of the complications, of which the most frequent was bronchopneumonia. This last complication was due to the presence of the streptococcus, and it was that microbe which rendered so dangerous the admission of a patient suffering from measles to ill-kept children's wards. The micro-organism was so much the more to be dreaded that in the malady in question the mucous membrane of the air passages had lost their protecting epithelium, rendering more easy the inoculation of all the pathogenic germs suspended in the air—tubercle, diphtheria, infectious pneumonia, &c. Consequently, if disinfection was useless against the measles properly called, the same could not be said of its complications. The speaker concluded by saying that it was dangerous to allow the public to believe any longer that there were no precautions to be taken against the contagion of the measles, and esteemed that that affection should be classed with the list of contagious disorders of which the declaration was obligatory.

LATENT ANEURISM.

Prof. Huchard communicated the case of a patient in whom aneurism of the aorta remained ignored for several years. The aneurism was seated in the thoracic portion of the aorta, and gave rise to sharp intercostal pain which obliged the patient to walk bent in two, and persisted in the horizontal as well as in the upright position.

The pain, which occupied the base of the thorax, and the ninth and tenth intercostal spaces on the left side, was attributed by several doctors to intercostal neuralgia, and treated as such without the slightest relief.

The characters of the pain on the one hand and syphilitic antecedents of the patient on the other, suggested to Mr. Huchard that the case was one of aneurism of the aorta, situated in the region designed by him under the name of *latent zone*. An attentive examination of the thorax showed, in fact, the existence in that zone of abnormal pulsation, with a slight expansive movement, which left no doubt on the presence of an aneurismal tumour of the aorta. Examination by the radiograph confirmed the diagnosis.

M. Rendu said that some time ago he attended an officer who suffered for five years previously from intense intercostal pain, and in whom the respiratory murmur was completely abolished on the left side. Although no physical sign of an aneurism existed, he pronounced the case to be an aneurism of the thoracic aorta pressing on the left bronchus. Some time afterwards the patient died suddenly in going upstairs, which fact seemed to prove that his diagnosis was exact. He knew, on the other hand, a woman in whom the intercostal pains, which had resisted all the means habitually employed against neuralgia, yielded to the influence of iodide of potassium. He believed consequently that it was another case of aneurism of the aorta.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, February 24th, 1900.

At the meeting of the Medical Society of the 7th inst., Hr. Cassel read a paper on

NEPHRITIS OF YOUNG CHILDREN.

During the past few years he had observed a series of symptoms in nine young children from six weeks old to two-and-a-half years. Without precedent scarlatina, and with a sound heart, the children had œdema, three of them with ascites, whilst no albumen was present during any part of the illness, nor any trace of sediment or casts. Ætiologically the cases were not all alike. In two of them there was said to have been a rash 14 days before. The speaker suspected this was varicella from the description. In some of the children the spots were still visible. In one of the children measles came out after the œdema without influencing the course of the latter. In four of the children disturbances of digestion preceded the swelling, in one case no ætiology could be discovered. Scarlet fever could be absolutely excluded, as also lues and tubercle. Two of the children were withdrawn from treatment in from 10 to 12 days, four recovered, and three died. The urine carefully collected and examined was clean, colourless, slightly acid, and of low specific gravity, and as said contained no albumen. The quantity varied considerably. Two autopsies made explained the nature and causes of the symptoms. The first in 1897 was made on a child of six weeks, nourished artificially. It suffered from acute intestinal catarrh, with vomiting of a green watery fluid, there was intertrigo on the nates, after a week's treatment some improvement took place, but when cow's milk was given for a few weeks, the child became worn with obstinate bron-

chial catarrh and excessive paleness. After some weeks the œdema got worse, and it finally died of hypostatic pneumonia. There were no uræmic convulsions. There was but little fluid in the abdomen, a teaspoonful in the pericardium, the heart not enlarged, musculature and valves normal. The kidneys were not enlarged, the capsule was softened, the surface quite smooth, the consistence very soft. There was swelling of the epithelium, and partly degeneration, the canaliculi dilated to five or six times the normal, plugged with detritus, and cells of various kinds, in part with epithelial cells from the canaliculi in part with coloured nuclei and nucleoli, and necrotic renal epithelium. The second autopsy was made on an artificially fed child of seven weeks, who had presented similar symptoms of intestinal derangement, the heart was not enlarged, there were some hepatised spots in the lungs, the solitary follicles with colon were swollen. The spleen was very red; the capsule could be stripped off. The medulla of the kidney reddened, the glomerules rich in nuclei, exudation in certain spots, with only rare small celled patches, which were scattered through the cortex, bloodvessels filled with red blood corpuscles. It was evident the kidneys had undergone considerable alteration of structure.

As regarded the literature of the subject, Phillips, of Berlin, in 1840 described an epidemic of scarlatina in which he saw at least one hundred cases of œdema, in sixty of which there was absence of albumen in the urine. An Italian physician, Henoch (1870); and Litten (1873) had described cases, and after them a large number of observations had been made. Henoch explained œdema after acute and subacute intestinal catarrh by failing energy of the heart, and thrombosis of large veins, but pointed out that nephritis must not be lost sight of. Filatow held that these forms of anasarca had nothing in common with nephritis, as there were no albuminuria and no uræmia. The capillaries of the skin were damaged by the circulatory portion, and the nerve centres of the heart participated in the evil results. The speaker thought these views, however, were theoretical, whilst his own preparations pointed to the firm basis of fact, so that in such cases he should always keep the possibility of nephritis in mind.

Hr. Senator thought Cassel's communication very interesting, as it disposed of the prevalent view that œdema was caused by the loss of albumen. Possibly in these cases the canaliculi were blocked in places only, so that the urine came from healthy parts. Any other explanation could scarcely be drawn.

Hr. Israel had seen a case in an adult where for months there was no albuminuria, although there was double nephritis with extensive necrosis and fatty degeneration of the epithelium.

Hr. Bajinsky remarked that dropsy in badly-nourished children was not so rare and was not pathological, and even when autopsies were made, what appeared at first to be nephritis might only be desquamation of the tubules, with excessive casting off of the epithelial layers.

Hr. Heubner did not doubt that Cassel's preparations were really nephritic. The daily quantity of urine passed was very important. In hospitals, when the whole quantity passed could be examined, albumen was always found.

Hr. Cassel remarked, in reply, that the salient point was whether in cases of cachectic dropsy, the kidneys

were found healthy at the autopsy. His preparations were undoubtedly nephritic, and although the daily total of urine was not collected, the absence of morphological constituents was remarkable.

At the Hufeland Society, Hr. Liebreich mentioned CERVELLO'S METHOD OF TREATMENT OF PHTHISIS.

He said the one great point was to raise the vital power of the cells and their power of resistance to the tubercle bacilli and other toxins. Commencing disease could be recovered from. One could not stand still at that, however, but had to go back to pharmacodynamics. Cervello had done this. He heated a formaline iodine preparation at a spirit lamp whereby formaline vapour was given off in the sick room, where the patient was made to breathe it for hours together. It caused no irritation of the air passages. Cervello, who had the finest sanatorium in the world at Palermo, had, according to his own statements, obtained very favourable results in his cases.

In the *Monatsch. Prak. Dermatol.* 99, Bd. 28 Unna warmly recommends the white indiarubber sticking plaster on spools of the Fabrik Becersdorf and Co., which has for him during the past few years become the means of fixature par excellence, wherever such is required whether on parts freely movable (knee and elbow) or elsewhere. It has not the energetic action of the zinc oxide, plastermull and zinc oxide parablaster in disease of the skin, but its absolute non-irritability and its cheapness, and its sticking properties render it superior in many ways. It is the ideal of a sticking plaster, and will certainly be the sticking plaster of the future. It can be procured not only in the ordinary breadth, but also in five different widths, 1.35 to 7.5 cm. and in lengths of 5 to 10 m.

ANTI-PNEUMOCOCCUS SERUM IN THE TREATMENT OF PNEUMONIA.

According to the *Deutsch. Med. Zeitung*, 98 99. Herren Banti and Pieraccini have made a prolonged and careful inquiry into the subject of the above-named treatment of pneumonia in the S. Maria Nuova Hospital in Florence, with the result of convincing both that the anti-pneumococcus serum has no influence whatever on the length of the disease, its symptoms or its complications. Neither was the mortality from the disease diminished in the slightest.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, February 24th, 1900.

GANGLIA.

At the last meeting of the Gesellschaft der Aerzte Budinger showed a male patient who had suffered from a ganglion on the dorsum of the left foot some years. A few months ago he slipped and fell, hurting the ganglion which suddenly enlarged from the third toe to the fifth, which Budinger diagnosed as a hæmatoma. He operated under this impression, but found the tendon as well as the binding sheath, but no pathological change could be observed in the tendon this was fastened with a suture, and the wound closed without any bad effect. He attempted to demonstrate the mechanism of this accident by another in the terminal phalanx.

SYRINGOMYELIA.

Schlesinger next exhibited two cases of syringomyelia

with unusually complex symptoms. The first had the right arm constantly turning which caused the patient considerable pain. Along the entire right side from foot, hip, thorax, neck, face to head the tactile sensation was exalted to a degree of pain to the patient, as well as the temperature sensation. The right shoulder was dislocated, and the scapula could be carried far away from its natural position. The morbid process he concluded had penetrated to the upper part of the cord, as well as the medulla oblongata.

The second case commenced after an accident to the left hand which gradually became emaciated, this emaciation extending up the entire limb, although the muscles were atrophied fibrillary contractions were present. The muscular power of the arm was diminished but the tendon reflex was increased. The sensation was partially gone in both arms from the hands to the elbows. During the last two years fluid food was occasionally regurgitated through the nose; this temporary bulbar paralysis is not a common attendant in the disease, although prominent in this case. There was, however, an absence of atrophy of both temporal muscles and Dupuytren's tendon contractions which are usually associated with the symptoms of springomyelia.

SCLERODERMA.

Spiegler brought forward a young woman with scleroderma having a reddish-brown colour, on the right mamma, about the size of a child's hand. When it first appeared it had a bright red appearance with well defined margin which led to the erroneous diagnosis of erysipelas.

The aetiology in this case was very obscure as there was no disturbance of nerve system, or pressure of corsets to account for the morbid changes; yet the latter must be accepted as suspicious, although subjectively no direct testimony can be vouchsafed on its behalf. In very sensitive skins very slight causes occasion œdema, which afterwards become sclerotic. There is one case on record where the wearing of a vest produced a similar change.

ENTEROPTOSIS.

Herzfeld finally read an exhaustive paper on enteroptosis (*εντερον*, intestine; *οπτος*, parched) which is seldom treated with the merit it deserves. It is more commonly associated with the female sex although it is not unknown in the male sex also. It is especially peculiar to a disturbed state of the digestive organs, and may be located to the stomach by the symptom of loss of appetite, a constant hungry feeling, or pain after taking food as if pressed or struck; or it may be located to the bowel by the presence of constipation, sudden diarrhoea, flatus, increase of abdomen with a swollen feeling, &c. These conditions often lead to severe discomfort, inability to move or work, even impeding the respiration, producing alarming palpitation, which may end in a disturbance of the circulation, vertigo, cephalalgia, nervous troubles, and rapid emaciation.

Glénard first attempted to demonstrate to the profession that this state was due to a lax condition of the ligaments in the flexura coli hepatica, thus permitting of a sinking of the colon ascendens and transversum, which subsequently produced a dragging on the other surrounding organs.

This theory is now almost exploded, as the causes may be so numerous and the symptoms so varied that no single fact can be charged with the offence. It is often met with from thoracic pressure, enlargement of the

liver, distension of the bowel, tight lacing, pregnancy, &c., &c.; indeed, anything that will reduce the tonus of the abdominal coverings may produce it. Hence it may be due to external causes as well as internal, being due to anything that disturbs the normal resistance. Herzfeld believes that the real cause is due to a dilated form of the blood vessels remaining after any of these causes that subsequently produce a chronic hyperæmia with general disturbance of the circulatory system evinced by the later stages of anæmia, excessive menstrual hæmorrhage, &c., &c.

The therapy most successful is nutrient dietetics, baths, massage, proper body supports, both external and internal, electricity, gymnastics, &c., &c., combined with constant regulation of all the internal organs.

Special Article.

THE ENGLISH MEDICAL MAN IN THE TRANSVAAL.

THE medical man who wishes to succeed in the Transvaal must be prepared to forego most of the ordinary comforts of life, and to rough it in the most literal sense of the word. Ninety per cent. of the population of the Transvaal lives away from the towns and villages, and it is a common occurrence for a doctor to be called on to start away for a sixty or seventy miles ride at any hour of the night or day. The Boers, to a great extent, depend on their own homely remedies in any slight illness. Should these not prove efficacious the trading store will be ransacked for some patent remedy, and in the event of this also failing to have the desired effect a messenger will be despatched post-haste for the doctor. Every medical man who goes to the Transvaal is not an expert horseman, but as many of the people live in inaccessible parts of country, which can only be reached by an ordinary conveyance by making a long détour, and as time is, of course, of the first importance that doctor will, as a rule, sacrifice his personal feelings, and start away on horseback. During the time he will be away from home he will have to trust to "pot luck." He will have to sleep in beds of every degree of hardness, and sometimes in no bed at all, he will have to live on boiled mutton and coarse brown bread, washed down with muddy coffee. He may be away three days, he may be away a week, probably to find on his return another call awaiting him from some other direction. It may be also that the doctor has gone to all this trouble for nothing. On one occasion a doctor was summoned to attend a sick Boer. On his arrival at the farm the "patient" met him at the door, and said that "he was alright again now, and so he (the doctor) had better have a cup of coffee and rest his horse before he started off back again." In this case the doctor had ridden forty-seven miles at this man's summons. The patient had been prostrated with a severe attack of cramp in the stomach, but repeated applications of hot water externally, and Dop brandy internally, had relieved him, and he was, as he said, "alright" when the doctor arrived. Not a word was mentioned about payment and when the doctor sent in his account the Boer seemed quite annoyed. "Why," he said, "I was alright when he arrived, he did not do anything for me," and it was only after the Landdrost had been called in to intervene

that the doctor received a portion of his account. The English doctor in the Transvaal has a powerful rival in the Hollanders. The latter can of course speak the language sufficiently to make himself understood and can understand the Boer himself (for the Hollander speaks a different language to the Boer), but once the Englishman picks up the "Taal" he generally forges ahead, for whatever his feelings towards us may be the Boer believes the Englishman is the most "slim" person in the world, and would always rather consult an Englishman than anyone else, provided that he can explain matters to him. There will be a great opening for young medical men in the Transvaal once the present "difficulty" is over.

The Operating Theatres.

ST. THOMAS'S HOSPITAL.

PAROVARIAN TUMOUR WITH ROTATION OF PEDICLE AND ADHERENT INTESTINES.—MR. W. ANDERSON operated on a woman, æt. 43, who was admitted with a tumour in the lower part of the abdomen, associated with symptoms of localised peritonitis. She said that she had noticed the tumour twelve months before, but during the past three weeks it had been apparently increasing in size, and was associated with a good deal of local tenderness. On examination a rounded tumour was found extending across the middle line into the right iliac fossa, and probably from the left side, where the growth appeared to have commenced. The intestines were displaced upwards and to the left side, and a certain degree of tenderness was noticeable in the latter situation. An incision was made a little to the left of the median line below the umbilicus; on introducing the hand, the tumour could be felt tense and oval; the exposed surface was somewhat dull and dark, and showed one or two flakes of lymph; on tapping with a small trocar a quantity of reddish brown fluid escaped, and after complete emptying the cyst was partially withdrawn from the abdomen. Several coils of small intestine and sigmoid flexure were then found adherent to the left side of the tumour near its pedicle, and the growth in this neighbourhood showed signs of extensive inflammation. The adhesions, which were apparently of some week or ten days duration, were broken down and cut through, and the pedicle when freed was found to have undergone rotation through about two-thirds of a circle. This was then ligatured strongly, and the tumour removed. The opposite ovary and broad ligament were found to be normal. The abdomen was then closed, separate stitches being used for the peritoneum, muscular walls, and skin. Mr. Anderson remarked that this was a case of parovarian cyst, which had undergone a partial rotation and consequent inflammation, the adjacent intestines had become glued to the growth in the neighbourhood of the pedicle, the point of maximum inflammation, but fortunately the adhesions were neither dense nor vascular. The danger caused by this condition was not likely to be an immediate one, and the patient would probably recover within the usual period after a successful operation but it would be necessary to watch for a long period for the possible supervention of intestinal obstruction secondary to the somewhat extensive peritoneal adhesions between so many coils of gut.

OPERATION FOR VENTRAL HERNIA.—MR. BATTLE operated on a woman, æt. about 40, who was the subject of ventral hernia. Ten years ago ovariectomy was performed, and the scar remained well for some months, but gradually, in consequence of increasing corpulence and two or three confinements it had yielded irregularly and permitted of escape of omentum. For some days the lower part of the swelling had been painful and she had suffered much discomfort; she had also suffered from troublesome cough. On admission she was a big, stout, plethoric woman weighing 14 to 15 stone, who presented an irregular swelling in the middle line under the lower part of an old scar. The lower part of the swelling was obscured by redness and œdema of the skin, whilst the skin over the upper part was thickened from the œdema. It was of irregular shape, lobulated, and whilst some of the lobules could be partly reduced the majority could not be pushed back, and this was more especially the case with the inflamed part. There was a slight rise of temperature, but otherwise, beyond the pain caused in the tumour by her coughing, she had no symptoms. She was kept in bed for some days, and hot fomentations applied to the abdomen, whilst the cough was treated with appropriate medicines. When inflammation had subsided and her cough improved a radical cure of the hernia was undertaken. An incision was made on the right side of the swelling, and the adherent omentum separated from numerous irregular loculi, and returned into the abdominal cavity. There was more than one opening leading through the middle line, so that the hernia might be called a compound one; the lowermost of these openings was occupied by adherent omentum, which had been recently inflamed, and the interior of the loculus, to which this was attached contained a rounded body about the size of a walnut, which was attached to the peritoneum lining the sac by recent adhesions; there seemed no other source of vascular supply. It appeared probable that this unusual body was separated from the omentum and changed by inflammation. There had probably been some hæmorrhage into it. The whole of the sac was now dissected away from the edge of the opening to which it was adherent, and the abdominal wall defined in three layers, peritoneum and subperitoneal tissue, united by a row of interrupted sutures, the fibrous tissue and muscular coat, where exposed, were sutured first of all in a single layer, and then a reinforcing layer was inserted from side to side like Lembert's sutures, and the parts laced together. The skin was then closed over it. A drainage tube was put in to be retained 24 hours. Mr. Battle said that it was a case in which radical cure should be attempted, for the condition was getting worse from month to month, and the patient suffered much pain. If nothing were done, it was very probable that strangulation would ensue at some time when she was suffering from bronchitis, and was unable to bear the necessary anæsthetic. He considered the reinforcing stitching he had put in effected a considerable strengthening of the wall and the union at that point would be very strong. He had used this method in similar cases before, and it had given him satisfaction. The finding of the rounded body referred to above was interesting, he thought, but it was difficult to say the exact manner in which it had been formed.

It looked fatty; there had been hæmorrhage into it, and recent inflammation around it.

It is satisfactory to say that a fortnight after operation the patient was going on well, although the anæsthetic had caused a temporary return of the bronchial cough.

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“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, FEBRUARY 28, 1900.

THE MORTALITY FROM DISEASE AT THE WAR.

In every campaign conducted upon a large scale the mortality from disease among the troops is expected to reach a high ratio, for despite the care that may be taken to attend to sanitary and hygienic details, the conditions which conduce to disease are everywhere present. A few of these may be mentioned. In the first place the food and water supplies are necessarily for the most part defective in armies on active service. The exigencies of the operations in progress make it impossible for the troops to receive proper nourishment; the food may be poor in quality, or lacking in quantity, while the water supply has to be drawn from the district in which the army is operating. Thus, while for a time the health of the troops may remain fairly good, before long the unavoidable privations and demands upon their strength begin to be felt, and disease in some form or another acquires a prevalence which tends generally to increase with the progress of the campaign. So far as our forces in South Africa are concerned, no excessive death-rate from disease has up to the present been recorded. This is not surprising in view of the natural healthiness of the climate. But the signs are not wanting that the trials of the campaign are beginning to tell upon the troops. Of course, in the beleaguered towns such as Ladysmith, and, until lately, Kimberley, a high and increasing mortality has obtained; this, however,

has been only the natural sequence of the special and more or less desperate conditions to which the inhabitants and troops were exposed. In Kimberley, for example, some weeks before its relief was accomplished by General French, the community were reduced to eating horseflesh, and we learn that this proved so distasteful to the women and children that they refused to partake of it, and preferred to go without solid food of this description. There is nothing, then, surprising in the statement that the mortality among the children was exceeding high during the siege owing to lack of insufficient nourishment. Then with regard to Ladysmith the reports show that many cases of enteric and dysentery have occurred therein since its investment. In accounting for this, no doubt, it is needful to recollect the recklessness of the average soldier who, while suffering from severe thirst, is apt to be very careless as to the water that he drinks. In proof thereof, it has been stated that at the fight on the Modder River the troops passed a pond, and, utterly regardless of the apparently foetid condition of the water, were about to quench their thirst by drinking from it. The common sense, however, of the officers prevented them from carrying their purpose into effect. Stringent orders were issued forbidding the men to drink the water, and by this timely exercise of authority in all probability many a man was saved from an attack either of dysentery or typhoid fever. The real point, however, upon which reflection cannot fail to be concentrated in this connection is that the lessons afforded by the deaths from disease are capable of teaching very little. So far as the prevalence of typhoid is concerned at Ladysmith, the strong probability is that most of it has been due to the neglect of ordinary precautions. At all events, this conclusion is only a reasonable one, for it is natural to assume that persons residing in a town which is being daily bombarded would not be much disposed to trouble about the boiling of their drinking water when most of their time was taken up in avoiding bursting shells from the enemy. Thus the prevalence of dysentery—no doubt largely a water-borne disease—and typhoid is capable of being mainly accounted for. It is also of interest here to recall that after the battle of Omdurman many deaths from enteric subsequently took place and the source of the disease was traced to the foul water which the men drank from a ditch alongside the town, while oppressed with an overwhelming thirst. It seems indisputable, therefore, that nothing is to be learnt from the mortality rate from disease which attends warfare; most of the deaths, under ordinary circumstances, would presumably be prevented by attention to those measures of precaution such as prudence and knowledge would dictate. But the circumstances are always far removed from the ordinary, and matters of more urgent moment claim the almost sole attention of all engaged in the campaign; consequently it happens that matters of health, important though they be, are apt to be neglected, with the result that a heavy death toll is exacted, and many valuable

lives lost, which might have been saved had better care been taken.

THE HOUSING OF THE WORKING CLASSES.

THE social importance of the movement that has been reduced to practical legislation in an Act bearing the above title must be apparent to everyone who has pondered the problems of latter-day civilised life. The health of the community, a mainstay of the national edifice second only to its wealth, is closely involved in the wisdom or otherwise with which this question is handled. When, therefore, it was known definitely that the present Government, the "strongest of modern times," were about to consolidate and amend the Housing of the Working Classes Act, 1890, it was generally hoped that Parliament would be asked to approve a measure characterised by strength, breadth and soul-convincing thoroughness. Such anticipations, however, have been doomed to disappointment. The great occasion has come and gone, the mountains have laboured, and a *ridiculus mus* has been brought forth in place of the sturdy young giant whose advent was not unreasonably expected. Last Thursday Mr. Chaplin obtained leave to introduce a Bill to amend the third part of the Act of 1890 relating to the Housing of the Working Classes. He proposed to give power to the London County Council, and to other local councils throughout the country, to acquire land beyond their area for the purpose of providing suitable dwellings for the working classes. The concession therein involved is valuable, but it does not touch the vital defect of the 1890 Act, that is to say, its cumbrous and costly machinery. Under present conditions the Act is shelved by the majority of Medical Officers of Health, except so far as a limited use of Part II. is concerned. It has been made apparent to them by experience that it is easier to close under the Public Health Acts, and better where a house is not too bad to be put in tolerable sanitary order. For the benefit of readers who are not conversant with the Housing of the Working Classes Act it may be well to set forth briefly a few of the chief features of that well-intentioned but disappointing effort of legislation. The Act is divided into three main parts. Part I. deals with unhealthy areas, both as to clearance and re-housing schemes. Part II. deals chiefly with dwelling-houses unfit for human habitation, secondly with their demolition, and thirdly with the removal of obstructive buildings. Part III. gives power to local authorities to buy land within their districts and to erect lodging-houses for the working classes, or to acquire suitable houses for the same purpose. In London the administration of Part III. is vested in the London County Council and in the country powers are obtainable with sanction of the Local Government Board. A curious anomaly arises from this arrangement, inasmuch as a small rural district can thus obtain facilities that are denied to rich and powerful Metropolitan Vestries and Boards of Works. It is impos-

sible to enter at length into the details of the present Act, but the broad statement may be made that for confusion, complication, and inadequacy it stands well-nigh unrivalled. Mr. Chaplin has done little in the direction of remedying those deficiencies. Dealing with Part III., he proposes to grant local authorities power, as already stated, to acquire land for purposes of housing outside the limits of their own jurisdiction. His only other proposal is to simplify procedure in rural districts by dispensing with the necessity of approval of the Local Government Board, and substituting that of County Councils. Mr. Chaplin's amendments, to say the least, do not bear the stamp of great statesmanship. So far as London is concerned, from November next, under the recent London Government Act, the new local authorities thereby created will have power to buy land outside their own district for the housing of the working classes. This meagre instalment of legislation cannot be regarded with any degree of enthusiasm. The President of the Local Government Board has neglected the opportunity of erecting for himself a monument more enduring than brass in the shape of a great Act. As Sir Walter Foster remarked in the Commons, the question was one of tremendous importance affecting tens of thousands of people in London and hundreds of thousands elsewhere, who were living under conditions where decency was impossible and morality a miracle. That proposition certainly presents the pith of the matter with a direction of statement that is always most desirable in relation to public health matters. The Bill has been read a first time, but it is to be hoped that it will not be allowed to become law except in a considerably amplified and amended form. As it stands, the Bill is a feeble, inadequate, and unsatisfying compromise, embodying the worst defects of patchwork legislation. Instead of the bread craved for by ardent sanitarians, Mr. Chaplin has incontinently thrown them a stone. This question serves to demonstrate once again the absolute need of a strong body of medical men in the House of Commons. The Government that pottered the principle of compulsory vaccination is hardly likely to show greater breadth and intelligence in dealing with other matters of prime importance to the community in the practical administration of preventive medicine.

IS SUICIDE ON THE INCREASE?

SIR JOHN SIBBALD has for some years been known as a special authority on the statistics of suicide, a subject to which he has given very careful attention, from which he has drawn very cautious and, which will be admitted by those best qualified to judge, very sound deductions. A few days ago he delivered before the Royal Society of Edinburgh, an address on "The Statistics of Suicide in Scotland," and his conclusions will be read with interest on this side of the border, as well as on the north, because he has dealt with a subject regarding which

there have been too many pessimistic views, and moreover, he has dealt with it in a manner which leaves little doubt as to the result. He pointed out that the numbers given in the Registrar-General's reports showed a steady increase in Scotland just as shown by the official numbers for almost every other country. The Scotch figures showed an increase from an average rate of forty per million in the five years 1865-1869 to fifty-four in the years 1890-1894, an increase of 35 per cent in thirty years. The English rates had been persistently higher than the Scotch, but their proportional increase was somewhat less. The figures had been generally accepted as showing that suicide had increased to a great and perhaps alarming extent in recent years. Sir John is quite satisfied that it is wrong to accept that view as well founded. In his words, the time has now come for subjecting such figures to careful criticism before accepting them as correct representations of the facts. We agree with him that in these, as in other similar sets of statistics, there is too great a tendency to accept official figures without carefully weighing their value, and without noting the fact that their value at one period may be different to their value at a subsequent period. In regard to suicide, Sir John observes, the state of public feeling and the degree of efficiency of the registering machinery must be kept in view. It is well known that in recent times great changes have taken place in public feeling in regard to this matter. The belief that an act of suicide necessarily involved disgrace has greatly diminished, since suicide has been recognised to be, in at least a large proportion of cases, the result of mental disease, and in consequence of this change of opinion efforts to conceal its occurrence have correspondingly decreased. The administrative machinery for ascertaining the occurrence of suicide has also, during recent years, been developed and made more efficient. How far we should accept this statement of Sir John Sibbald's may be a matter of opinion. There is certainly a considerable element of truth in it, particularly as regards the last clause of the statement, but there is just a chance that we may make too much of the argument that suicide is less regarded as a disgrace and more regarded as a result of disease than formerly. We may, however, pass on to some points of practical interest affecting the subject, points which Sir John clearly drew out in bold relief. In subjecting the official figures to critical examination he drew attention to the fact that all suicides in Scotland—and the same is true of England—were due to wounding, poisoning, drowning, and hanging, with the exception of eight per cent. due to other methods. He very pertinently observed that this fact is of great assistance in examining the value of the figures, and in determining whether certain deaths were due to suicide or not. Thus, for example, a death from hanging could hardly be concealed, and when known, could hardly be regarded otherwise than as suicidal. He, therefore considers it an important fact that during the thirty years already mentioned the rate of hanging in Scotland has remained

unchanged, being sixteen for the first fifteen years, and sixteen for the last fifteen years. It is instructive to find that in England the rate of hanging is also practically unchanged, being twenty-six for the first fifteen years, and twenty-five during the last fifteen years. Into further details space forbids our entering, but we may say this with convictions optimistic, and we may almost say, justifiably optimistic, that certainly it would be foolhardy for any one to step forward now and attempt to demonstrate that suicide is on the increase. It is said that the percentage of suicides is greater on the east coast than on the west, and what the real explanation of this may be is likely to be matter of dispute for the present, for it can scarcely be a mere question of east wind *versus* west wind, though it is possible there may be something in the exposure, but we cannot exactly say why. Dr. Clouston, in discussing the paper, trots out his old theory that excess of alcohol induces to a condition of brain which frequently leads to suicide. This, however, is probably being made too much of. We, however, join with Dr. Clouston in saying that "up to the reading of Sir John Sibbald's paper, all recent authors on the subject had put down suicide as being an increasing quantity in modern times; but his statistics and his mode of looking at things would cause all to put a point of interrogation at what perhaps would have otherwise been an universal conclusion."

Notes on Current Topics.

Quack Medicines and their Increasing Sale.

If a quack may be defined "as a boastful pretender to knowledge which he does not possess," we presume that a quack medicine may be described as "a secret concoction for which virtues are claimed in a pretentious and ignorant manner." In connection with this subject the Folkestone Medical Society recently passed a resolution to the effect that "this society is of opinion that the use of patent and proprietary medicines is largely on the increase, and is a public danger." This was a very sound and practical conclusion to have arrived at, but it will not be of much avail unless something more is done to bring it under notice. The Folkestone Medical Society would be inaugurating a good work if they became the pioneers in a campaign against the sale of quack medicines. They might issue copies of their resolution to other medical societies, and, if possible, obtain the concurrence of the latter. Moreover, they might attempt to gain an authoritative reply to the question regarding the necessity of bringing forward legislative measures bearing upon the subject. No doubt a law should be in force compelling the proprietor of every quack medicine to publish the formula of the latter with every package that he sells of his stuff. This, as is well known, is the rule which obtains in Germany, and there is no possible reason for not adopting it in this country. For the sum, however, of £230,000, which represents the annual amount of

duty paid on patent medicines, the Government have always refused to favour any proposal of the kind. They prefer to encourage the trade in quack concoctions on account of the revenue which they derive from the duty on the sale thereof, thus quite ignoring the harm which possibly results from the indiscriminate and wholesale dosing of the public with unnecessary and often undesirable drugs. Of course, the argument may be advanced that the public are under no compulsion to dose themselves with the quacks' alluring concoctions, but the answer is that the stamp which the Government issue as proof of payment of duty is regarded most generally by the public in the light of a guarantee that the concoctions are trustworthy and authorised. Even if some steps were taken by the Government to indicate that this was not the case, a great point, no doubt, would be gained, but experience in the past has shown that no legislative interference with the sale of quack commodities is ever likely to be undertaken by the Government of the day.

The Health of Mr. Treves and his Nurses.

The Central News Agency has reported that Mr. Treves has been ill from a bad attack of dysentery, and has had to leave the front, and go down to the coast in order to recuperate. If his health permits of it, however, he will return to the Tugela for a time, but his intention is to leave for England in the course of next month, some pressing engagements requiring him to do so. With respect to the health of his nurses, it was reported a short time ago that one of them had died from typhoid fever, but the mystery surrounding this rumour has been disposed of by Mr. Treves in a communication addressed to a contemporary. In a letter to our contemporary he states that the nurse in question, Miss Tarr, was attacked with dysentery, and the disease was of so severe a type that her life at one time was despaired of. She was removed to the hospital at Maritzburg, and here, it is satisfactory to note, she is now doing well. The other nurse appears to be in good health.

Chemists' Adulteration.

SANITARY authorities throughout the kingdom are beginning to show signs of an awakening interest in the Adulteration Acts. In one important direction there has hitherto been practically no control, namely, that of the purity of drug and druggists' wares. Last week a Camberwell chemist was prosecuted for selling camphorated oil which was not of the nature, substance, and quality of the article demanded by the purchaser. An analysis of the stuff showed that it contained 80 per cent. of mineral oil. According to the directions of the British Pharmacopœia one part of camphor should be dissolved in four parts of olive oil, so that the substitution was of a serious nature. The magistrate imposed a fine of £20 and costs. It is to be hoped that this exemplary decision will stimulate sanitary authorities in general to a more stringent administration of the Sale of Food

and Drugs Act. Chemists often try and justify themselves for giving unqualified medical advice to the public on the ground that medical men trespass on their preserves by dispensing physic. As we have often pointed out, however, medical men are legally entitled to make up medicines, whereas chemists are not legally qualified to give medical advice. The chemists, however, will now have an opportunity afforded them, so we may hope, of setting their own house in order. Fortunately we have a good standard for the purity of drugs in the shape of the British Pharmacopœia. The abolition of plurality among the public analysts will be a necessary step towards a sound supervision of the drugs and food-stuffs of the community.

A New Sanitary Board at St. Olave's.

SOUTH London is at times curiously unequal in its sanitary administration, and one of its latest feats has been the construction of what amounts to a new sanitary administration by superseding the Medical Officer of Health. Recently Dr. Bond, who acts in the capacity mentioned at St. Olave's, condemned certain premises. The Works and Finance Committee thereupon made an inspection, and reported that although certain ground-floor rooms were "undoubtedly dirty," some were already closed, and others would be much improved by whitewashing and cleansing. The committee did not consider there was any legal evidence that the premises were unfit for human habitation. Their report then went on to contravene Dr. Bond's statement that the deaths in those particular tenements were fifty per thousand living. In the absence of definite information as to how those figures were arrived at they refused to accept them, as they felt convinced there must have been some error in calculation. Dr. Bond was not allowed to offer any protest or explanation. This incident involves issues of wide importance to the future of preventive medicine, not only in St. Olave's but throughout the length and breadth of the United Kingdom. If such treatment of a Medical Officer of Health were tolerated, that official might be practically superseded by an irresponsible sub-committee in every sanitary authority in the kingdom. Fortunately, one or two small but weighty points appear to have been overlooked by the autocratic Works Committee of St. Olave's. First of all, Parliament vests full power in the Medical Officer of Health to condemn premises as unfit for human habitation upon his "opinion," which is therefore the one essential and indispensable precedent condition. St. Olave's has resolved to take no further action, but either the County Council or the Local Government Board will doubtless step in and do the work for this unruly Board of Works, which only a few months since was directly coerced by the Local Government Board.

THE Inebriates' Amendment (Scotland) Bill passed through Committee in the House of Lords early last week, and was then read a third time.

The Registrar-General for Ireland.

MR. ROBERT EDWIN MATHESON, Assistant Registrar-General, has been promoted by the Lord Lieutenant to the chief command of this very important department. We have, since the death of Dr. Grimshaw, urged the pre eminent claim of a member of our profession to occupy the position, and we adhere to the opinion that, neither in England nor in Ireland, should the Registrar-Generalship be held by anyone save a medical practitioner, and we maintain that for the duties of registering deaths, diseases, and births, no person can be competent without expert knowledge or expert assistance, which will, we trust, be provided for by the appointment of a capable medical statistician in association with Mr. Matheson. Nevertheless we recognise in Mr. Matheson the best man, outside our profession, who could have been selected. Mr. Matheson, who is a brother of Mr. C. L. Matheson, Q.C., has been connected with the department of which he now becomes chief since his eighteenth year, and has risen through all its sections, becoming, in the meantime, perfectly familiar with its work and routine. Since 1863, when he first became connected with the staff, many important changes have been made in the system of the great statistical office, and in the initiation of most of them Mr. Matheson has taken a prominent and useful part. Mr. Matheson studied law in the Middle Temple, London, and at the King's Inns, Dublin, and was called to the Irish Bar in 1875. In 1877 the position of secretary to the department was created, and Mr. Matheson, who by that time had passed through the leading sections of the department, was at once chosen as its first occupant,

Quack Disinfection.

THE weakness of medical legislation in protecting the public against the assaults of unqualified practice is every day abundantly illustrated in the annals of newspaper literature. An extraordinary case reported last week from the East-end of London shows that the province of the Medical Officer of Health is being invaded by the ubiquitous quack. From a report of the Medical Officer of Limehouse we learn that a herbalist informed him he had attended three diphtheria cases, and had subsequently disinfected the house. He went to the house, where he found three children affected, and three others also suffering from the disease were playing out in the street. He sent all six to the fever hospital, where five of them were promptly put on the dangerous list. The Vestry, on receiving this information, discussed at length the question as to whether the herbalist could be proceeded against. The opinion of the Medical Officer was that he might possibly be brought to book by the Pharmaceutical Society, but then only if he sold poison in his drugs. The Sanitary Committee was instructed to communicate with the Medical Council. As the subject thus opened up is one of first importance, both to the public and to the medical profession, it may be permissible to point out that the sale of medicines,

apart from poisons, is sufficient to bring an unqualified practitioner within the purview of the Society of Apothecaries. If the drugs were supplied for disinfecting purposes the offence would probably have been committed no less than if they were furnished in the form of Physic. This point we would suggest should be submitted to the Medical Defence Union, to which body all Medical Officers of Health should belong. The General Medical Council never undertakes the prosecution of unqualified quackery, but confines its attention to those who have passed the rubicon of medical qualification.

The Oral Instruction of the Deaf.

THE society for training teachers of the deaf, and for the diffusion of the so-called German, or pure oral system, held their festival dinner at the Hotel Cecil on Wednesday, the 21st inst., with Earl Egerton of Tatton in the chair, supported by a large number of distinguished members and guests. The existence and objects of this humane society are, perhaps, not as generally known and appreciated as they deserve to be. The aim of the society is to disseminate a knowledge of the oral system of instructing the congenitally deaf, which alone will enable these unfortunate children to speak like other people, and to follow the speech of others by watching their lips. In the realisation of this programme the first step was obviously to train a sufficient number of teachers, and the progress of the cause may be gauged by the fact that the society has trained and certificated 113 teachers of the deaf, who have been, or now are, engaged in teaching the deaf and dumb to speak and to understand others. Incidentally the society has been the means of inducing the Education Department to endorse the recommendation of the Royal Commission that all children thus afflicted should have the benefit of a course of training on these lines. The chairman, in proposing the toast of the evening, announced that large and immediate donations were required to put the finances of the society on a satisfactory footing, and enable it to proceed to the accomplishment of its programme, and in replying thereto, Dr. E. Symes Thompson, the chairman of committee, testified to the good work done and being done by the society, and endorsed the chairman's appeal for further support. We feel sure that the cause only has to be brought to the notice of the charitable public to secure the funds to carry on this beneficent work, though we are strongly of opinion that the duty of providing for the training of the poor "deaf and dumb" is one which should properly fall upon local educational authorities, the State intervening only to the extent of providing a supply of efficient teachers.

THE Midwives' Bill, as at present arranged, stands on second order for Ash Wednesday, but the chances of its coming up for discussion appear to be very remote. Even if it did the likelihood of its being "blocked" must be apparent.

Drunkenness and the Weather.

MR. E. G. DEXTER has taken the trouble to analyse the records of the New York City Police Force for three years in respect of arrests for drunkenness, and has considered their bearing as affected by the prevailing meteorological conditions. His results, published in a recent number of *Nature*, are singular enough to excite interest. He finds, for instance, that the prevalence of intoxication during the cold months was much in excess of that for the warm ones, December giving the police-court 47 per cent. more work than July. After discussing the bearing of certain possible factors, he points out that low temperatures made work for the police judge, while high ones lessened his labours. He suggests by way of explanation that the vitality of the body is lower in cold, than during moderately warm weather, and that this is the cause of the greater demand for stimulants, and on this hypothesis he urges that better heated tenements, warmer overcoats, and more nourishing food might do much to avert recourse to alcoholic stimulation during the cold season.

An Irregular Death Certificate.

At an inquest held in St. Giles' last week a curious irregularity in respect of the certification of the cause of death was brought to light. The child of a woman, who had been attended by a student of the British Lying-in-Hospital, Endell Street, died, and on information thereof being conveyed to Dr. G. H. D. Robinson, one of the visiting medical officers to the institution, this gentleman issued a certificate of the cause of death, leaving blank the name and address, and giving directions that it should be taken, with a letter he had written, to the coroner, in order that this official might decide whether or not the inquest was necessary. It transpired that the student had filled in the blanks, making it appear that Dr. Robinson had seen the child before death, which was not the case. The coroner pointed out the gross irregularity of such proceedings, and the jury expressed the opinion that the body of a deceased person should be viewed by the medical practitioner before signing the certificate, especially when he had not seen the deceased alive, or shortly before death, adding that as there was no residential medical officer at the British Lying-In Hospital the propriety of establishing telephonic communication between the institution and its medical officers might well be considered.

A Quasi-Live Burial.

A WELL-AUTHENTICATED case of what would shortly have been a case of live burial is reported from Southern Italy. A woman died, or was supposed to have died, as the result of a difficult labour, the foetus being left *in utero*. The body was placed in a coffin, and on the following day, before burial, when a photographer opened the coffin in accordance with the direction of the relatives, the woman was found to have turned over on her side, and close to her was the body of an infant, minus the arms which

had been removed during the obstetric operations. A judicial inquiry was set on foot, and the report concludes in favour of recovery from lethargy and death from suffocation. It is hardly necessary to point out that the change in position might conceivably have been caused by rough handling during removal to the mortuary, while the birth of the child is a phenomenon which has frequently been observed as the result of post mortem contraction associated with the onset of *rigor mortis*.

Medical Practice in Italy.

A CABINET Council has just been held in Italy for the purpose of considering the Bill shortly to be introduced into Parliament for regulating the practice of medicine by foreigners in that country. If the principle of reciprocity be not speedily recognised and adopted by the General Medical Council there appears to be every probability of restrictive measures being imposed. Now is the appointed time! There could not well be a more favourable moment for dealing with the subject, and it is to be hoped the members of council will give the matter their serious attention with this object in view.

The Physiological Effects of Boracic Acid.

MR. A. R. ANDERSON, F.R.C.S., of the Nottingham General Hospital, calls attention in a letter addressed to the *Lancet* to the physiological effect of boracic acid as observed by himself when giving the drug in ten to twenty grain doses in cases of bladder trouble. He has found that within a week or ten days symptoms of dyspepsia invariably developed, sufficiently acute to entail a tangible amount of discomfort; indeed so constant has this effect been that he is in the habit of warning patients to look out for it as an indication of the desirability of discontinuing its administration.

Immunity Against Scarlet Fever.

It is asserted that the Japanese enjoy a racial immunity against scarlet fever, and an American physician has even proposed to inoculate Anglo-Saxon children with the blood of Japanese infants as a means of securing protection against infection. This curious immunity, however, is not peculiar to the Japanese, for scarlet fever is reputed to be very rare in the western provinces of China, in Cochin China, Annam and Tonkin. It shows, moreover, little tendency to spread in South America, in Honduras, and in Jamaica. Whether this exemption is due to racial idiosyncrasy or to the climate being unfavourable to the specific organism is a moot question, but circumstances appear to point to race as the predominating influence. In India, where scarlet fever is also comparatively rare, the other exanthemata afflict the natives just as much as the white population. According to *La Médecine Moderne* there have only been twenty cases of the disease in twenty years among native troops numbering 235,000, while, during the same period, the European troops had sixty-two cases with two deaths. Even in France this disease is not as grave, nor does

it occur so frequently in epidemic form, as in Great Britain.

The Royal Army Medical Corps.

IN spite of recent reforms and ameliorations there is ample evidence that the medical service in the army is still far from being popular, a singular thing in view of the increasing difficulty experienced by young practitioners in finding suitable openings in civil practice. At the last competitive examination for the Army there were only seventeen candidates for forty vacancies, a discrepancy which is likely to be even more pronounced now that no less than a hundred commissions are to be offered. It is not merely a question of pay, for that factor does not seem to have operated in preventing candidates presenting themselves. It is rather the general, we might almost say the constitutional, want of consideration shown by military authorities for a very deserving, hard-working, and devoted class of officers. The government will now have to consider how best to create an effective medical organisation for the militia, yeomanry, and volunteers. One of the first points to consider will be the propriety of reducing the present ridiculous expenditure on uniform and equipment, which cannot but act as a deterrent to many practitioners who would otherwise be delighted to offer their services.

The Early Diagnosis of Impending Deafness.

ACCORDING to Dr. Bonnier, incipient deafness in persons who are predisposed thereto by reason of heredity, or as the result of chronic inflammatory affections of the nose or throat, may be diagnosed by the aid of a very simple test. The shaft of a large tuning fork in vibration is applied to any bony prominence, the knee, ankle, or elbow, or even on fleshy masses, such as the gluteal muscles, and the patient is asked whether, in addition to the vibration experienced at the site of contact, he also *hears* the tone. If really he perceives the transmitted sound, the ear being closed, there is evidence of paracusis, that is to say, a sign of impending deafness, for this form of paracusis, the author affirms, is peculiar to affections of the organ of hearing, and may precede all other manifestations of the infirmity.

Irish Local Government Amendment.

IT is some years since so impudent a Bill was offered to Parliament as the "Amendment" Bill presented by Mr. Tully, M.P., last week, which, to put it shortly, proposed that the central control of Guardians by the Government should be extinguished, and that the administration of the public business and the expenditure of the tax-payers money should be handed over to the village politicians in testimony to the admiration with which the nation regards their administrative capacity. The only thing which surprises us is that Mr. Tully, M.P., and his coadjutors can suppose that they gain anything by making themselves and their legislative proposals ridiculous

by such an enterprise as this. A nice place Ireland will be to live out of if ever the central control of these bucolic Solons is abandoned.

Dublin Hospitals.

THE election of surgeon to this hospital in place of Mr. Henry Moore, who has been elected to the surgeoncy of the City of Dublin Hospital, *vice* Mr. Wheeler, will take place on March 6th. In addition to Mr. Harry Croly, Mr. Burgess, and Mr. G. B. White, whom we have already named as candidates, we understand that Mr. Harvey, assistant surgeon to the Richmond Hospital, and Mr. Lane Joynt, of the Meath Hospital, and Mr. Albert Wynne are competitors. Dr. G. Jameson Johnston, Surgeon to the City of Dublin Hospital, has nearly recovered from the attack of diphtheria from which he has been suffering. Pending his resumption of the clinical work at that hospital, Mr. Harry Croly has been acting as his assistant surgeon in charge of his beds and of the class.

The Surgeoncy of the Queen's County Infirmary.

THE arguments in this case were heard by the Court of Queen's Bench in Dublin, on Tuesday, the 20th, and following days and yesterday. Tuesday was fixed for the delivery of the judgment of the court. The case seemed to depend a good deal upon the question whether, under the new law, the governors can dismiss an infirmary surgeon without satisfying the court that he was incapable or otherwise unfit for office, and whether, in this particular case, any such unfitness, on any ground, was capable of proof against the dismissed surgeon. We are debarred from expressing any opinion on these points as the court has not delivered its verdict at the time of writing. We can only say that, if the existing law is interpreted in the former sense, it will be a very serious matter for the Irish infirmary surgeons of the future who, in that case, would retain their positions only as long as they kept themselves strictly in line with the dominant politico-religious party.

The Proposed Midwives' Legislation.

THE editors of the *Lancet* recently sent post-cards to all registered English practitioners asking their opinion on the midwives' registration question. About a third of the number have so far replied, and of these 6,299, 1,817 consider that no legislation of the kind is called for, 1,530 of them adding that they are opposed to the Bill actually before Parliament. On the other hand, 1,323 are opposed to the Bill, but desire legislation for putting down unqualified practice. Further, 1,311 express themselves in favour of legislation on this subject as embodied in the present Bill. Lastly, 596 medical men declared their entire indifference on the subject. It follows that only 1,311 out of 6,299 are in favour of the Bill, a very significant result which cannot fail to carry weight with the Government in their attitude towards the proposed legislation.

THE Isolation Hospitals' Bill has been read a third time in the House of Lords without amendment, and has been sent to the Commons.

THE Dublin death-rate, which had fallen in three weeks from 37.0 per 1,000 of the population to 29.1, ran up again last week to 40.9. This has arisen, chiefly, from the prevalence of respiratory diseases and from influenza.

THE Society of Anaesthetists has enlarged its horizon in such wise that all duly-qualified practitioners who take an interest in the subject of anaesthesia and its production are eligible for membership.

THE Eighteenth Congress of Internal Medicine will be opened at Wiesbaden on April 18th, under the presidency of Prof. Von Jaksch, of Prague. The permanent secretary is Dr. Emil Pfeiffer, 13, Parkstrasse, Wiesbaden.

AT the next General Meeting of the British Laryngological, Rhinological, and Otological Association, which will take place on March 9th, at 4.30 p.m. at the Rooms of the Medical Society, 11, Chandos Street, W., a discussion will be held on "Conditions of the Throat and Larynx simulating and predisposing to Tuberculosis." It is to be opened by Mr. Lennox Browne.

IT is stated that Dr. Osler, the famous Professor of Medicine in John Hopkins University, Baltimore, is to be asked to allow himself to be nominated to the chair of the practice of physic in the University of Edinburgh. Though the Doctor is a Canadian by birth, he is a Fellow of the Royal Society and a Fellow of the Royal College of Physicians of London. His reputation is as great in the Old World as in he New.

THE Sanitary Institute Congress and Exhibition will not, as was arranged, take place this year at Nottingham. The large responsibilities which have been placed upon the county in connection with the war have made it difficult to assure the success of the meeting. With the approval of the Duke of Cambridge, president, it has therefore been decided to postpone the meeting.

THE application of a freshly-opened living pigeon to the head is still a popular remedy in France in cases of meningitis, and in the central market of Paris there is a poultry dealer whose speciality it is to provide pigeons for this purpose. She asserts that this branch of commerce is flourishing, and she has recently organised a farm in the environs for breeding therapeutical poultry.

THE latest suggestion for cutting the umbilical cord and keeping it aseptic is due to the ingenuity of Prof. Martin, of Griefswald, who advocates the use of curling tongs heated to a white heat. He first ligatures the cord close to its attachment, and then

burns it through, leaving a stump which is insusceptible of infection, and is safeguarded against accidental hæmorrhage.

PERSONAL.

MR. F. J. STEWARD has been appointed assistant surgeon to Guy's Hospital, and also assistant surgeon to the Great Ormond Street Hospital for Sick Children.

DR. DUDLEY BUXTON is to open a discussion on the "After-effects of Ether Inhalation, at the meeting of the Society of Anaesthetists on Friday next.

MR. W. A. SHEEN, son of Dr. Alfred Sheen, of Cardiff is about to proceed to the front as surgeon to the Imperial Yeomanry.

CAPTAIN J. E. CARTER and Lieutenant G. H. Goddard of the Royal Medical Service Corps, are among the wounded during Lord Roberts' recent operations.

SIR THOMAS SMITH, Bt., Surgeon Extraordinary to the Queen, has been appointed Honorary Consulting Surgeon to the Finsbury Dispensary, in succession to the late Sir James Paget.

THE marriage of Mr. Herbert Burrows Willett, eldest son of Mr. Alfred Willett, F.R.C.S., with Isobel, eldest daughter of the late James Matthews Duncan, M.D., F.R.S., will take place at Minstead, after Easter.

DR. F. W. PAVY, F.R.S., has been nominated by the Council for election to the office of President of the Royal Medical and Chirurgical Society at the Annual General Meeting on Thursday next (to-morrow).

MR. THOMAS MYLES, F.R.C.S., vice-president of the Royal College of Surgeons of Ireland and surgeon to Richmond Hospital, Dublin, has been appointed consulting surgeon to the Dublin Hospital for Diseases of the Skin.

SIR FRANCIS R. CRUISE, M.D., F.R.C.P.I., ex-president, Royal College Physicians, consulting physician to Mater Misericordiae Hospital, Dublin, and to the National Hospital for Consumption, has been appointed consulting physician to the Dublin Hospital for Diseases of the Skin.

MR. VICTOR HORSLEY is the recipient of formal congratulations proffered by the members of the Bradford and West Riding Medical Union "on the success with which he has struggled to defend the interests of medical practitioners against the continual neglect shown by the representatives of corporations on the General Medical Council."

WE regret to hear that Dr. Leith Napier, onetime of London, and recently of Adelaide, who has been acting as medical officer to the mounted contingent for South Africa, was thrown from his horse and sustained a fracture of the base of the skull. The latest bulletins testify to a slight improvement in the patient's condition.

THE war in South Africa has claimed another medical victim by the death from wounds of Captain Robt. H. Holt, of the Royal Army Medical Corps. He entered the Army Medical Service in 1892, and was gazetted a

captain in 1895. He was present during the fighting on the North-West India frontier in 1897-98, and received for his services the medal with clasps.

THE very valuable collection of literary and artistic treasures made by Dr. William Fraser, of Dublin, is to be sold early in March by Sotheby and Wilkinson. He was an enthusiastic collector of every good thing that was old. Etchings (including a unique selection of Albert Dürers), coins, medals, books, and old bindings, and, as he possessed rare powers of discrimination, and never bought faked-up antiquities, his collection has enormously increased in value. It has been sent to London for sale, chiefly because the purchasers of such treasures and the money to purchase with are scarce in Dr. Fraser's country.

MEDICAL SOCIETY OF LONDON.

At the meeting on Monday evening last (February 26th) Mr. MARMADUKE SHEILD reopened the adjourned discussion on "The Pathology and Treatment of Appendicitis," which occupied the entire evening. He was opposed to the administration of opium except in very moderate quantities, and he pointed out that the absence of induration over the cæcum was not in itself a reason for refusing operative treatment. He concurred in the view that rapidity of pulse was a very significant sign in these cases, and insisted on the importance of getting the bowels to act.

Dr. CAYLEY divided the cases into two great groups, those which might fairly be described as mild and those which were actually or potentially severe. The real difficulty arose in cases with severe initial symptoms in which, when seen early, it was virtually impossible to decide whether they would run a grave course or whether the symptoms would subside. Rapidity of pulse was significant, but they must take the collateral symptoms into consideration in deciding the question of operation. As to the administration of opium he thought it was of benefit provided it was not given until the question of operation or non-operation had been decided, and then only for the relief of pain and not continuously.

Mr. HARRISON CRIPPS thought that a mild first attack might be due to some accidental cause, and therefore did not necessarily require to be operated, but recurrence took the case out of that group, and indicated the lesion to be due to some abiding cause calling for surgical treatment. Operation during a quiescent period was practically devoid of risk, he himself had not had a fatal case, and Mr. Treves in his 150 cases had only two deaths. The presence or absence of swelling depended upon the position of the appendix and was not *per se* of any great significance. When there was very great induration it might be desirable to wait to see where the abscess would point. He objected to buried sutures, and said he had abandoned the use of any support to the abdomen after the operation.

Dr. HUNTER pointed out that appendicitis was always an infective lesion, so that the mild case of to-day might develop into the fulminating case of to-morrow. This fact should be borne in mind in deciding upon the treatment. He pointed out that suppuration often occurred after the disease had run a mild course of seven or eight days, and therefore whenever, after this lapse of time, there was even a slight rise of temperature he advised operation.

After some remarks by Mr. McAdam Eccles, Mr. MANSSELL MOULLIN said that in many cases in which the symptoms subsided suddenly this was due to discharge of matter into the intestine. In view of the risks which the condition entailed, the impossibility of ascertaining the exact nature of the lesion, and their inability to control its course, he urged that an operation was advisable in the majority of cases even at the risk of performing the operation in many cases which might have recovered without operation. The risks were small, and the patient was thereby guaranteed against recurrence.

Dr. LYNNE THOMAS, of Cardiff, said he had operated 41 times with only three deaths, and mentioned cases in which appendicitis had been diagnosed; in one of them it turned out to be pyosalpingitis, and in another an abscess of the right ovary. In a third case, he operated on a young woman and removed a healthy appendix. There was a recurrence of the symptoms, which yielded to a course of Weir Mitchell treatment.

After some remarks by Mr. Berry and Dr. F. Roberts (President), Dr. Allchin and Mr. Lockwood replied.

Literature.

TENTH ANNUAL REPORT NEW YORK STATE COMMISSION IN LUNACY.

THIS (Vol. i.) is a most elaborate work, and has an appearance of thoroughness. It is essentially American in character, and we might be disposed to criticise a profuseness of style and a method of administration which are of this essential character; but *cui bono*? Much of the statistical matter is of little interest, and the reports of committees on dress materials, marking ink, crockery, &c., is even more parochial than some of the methods which are contemptuously regarded, though we confess, extensively practised, by parochial authorities in this country. Why the time of medical superintendents should be taken up in full dress debates with motions and amendments on crockery we fail to understand, and why printers and bookbinders should be called on to immortalise such menial duties we are puzzled to explain. Unless that red tape is more than usually pleasing to the eye of our American cousins. This system must be very expensive, and though it may be good for the rank and file of the American machine it cannot tend towards economy of management on the higher efficiency of real medical work. The best part of this report, and even it might with advantage be pruned, in the interest of the reader, is a Preliminary Report on Dietsaries for hospitals for the insane. A certain amount of physiological explanation of an elementary character might be dispensed with. For these, however, who take the trouble to work their way through the report, repayment will result; for the differentiation of foods, their grouping according to nutritive equivalents, and the various tables of the state hospitals with their catalogue of foods, their percentage composition, and weights used should enable anyone who cares to take the trouble to frame ideal dietsaries in their relative physiological quantities, and in endless variety. We trust, when a continued report on this subject appears it will deal with the practical suggestions arising out of the first report.

Laboratory Notes.

CADBURY'S COCOA.

THE purity of this well-known cocoa is so established that it has come to be used as the representative standard of pure cocoa by analysts throughout the world. The use of cocoa as an alternative to tea and coffee has been for years advocated by the medical profession, seeing that it is a true food (which tea and coffee are not), and that it contains restorative properties peculiar to itself. In the early days of the Food and Drugs Act, when we analysed all the cocoas of commerce, it was common to find so-called cocoa to consist largely of mixtures of sugar and starch, with a comparatively small quantity of real cocoa, in some cases not more than a third or a quarter of the whole. When such mixtures are sold nowadays the fact of the addition of other substances must be set forth on the label, though it may be doubted if many persons take the trouble to ascertain clearly what it is they are buying; but it cannot be too clearly urged that pure cocoa, without any admixture whatsoever, is the best article for the healthy or sick, and that all mixtures should be avoided. In our exhaustive analyses some twenty years ago, Cadbury's came out of the ordeal as one of the very few pure

cocoas. We have recently conducted some further laboratory experiments, and find that this same cocoa contains no less than one-fifth of its weight of nitrogenous or flesh-forming matter, and more than one-quarter of its weight of the fat natural to cocoa, which is valuable as a nourishing and force-producing constituent. The characteristic natural alkaloid, namely, theobromine, was present to the extent of .9 per cent. The ash or mineral matter was that natural to pure cocoa, and amounted to .49 per cent., and it showed no added alkali.

The moisture was less than 5 per cent., that is to say, that the whole weight of cocoa purchased is actual food, whereas many ordinary foods consist largely of water, as, for instance, bread which contains half its weight of water, or butcher's meat which is nearly three-fourths water.

Microscopic examination confirmed the chemical analysis by showing the absence of all matter not naturally present in pure cocoa.

ECTHOL.

ECTHOL is the name given to a preparation containing the active principles of Echinacea and Thuja. Of these the former was originally introduced into therapeutics by Dr. H. F. C. Meyer as "an antispasmodic and an antidote for blood poisoning." In virtue of this property it is recommended in the treatment of malarial fever, cholera, furunculosis, infective sore throat, eczema, rheumatism, and dyspepsia. Echinacea is employed both internally and as a topical application, and it is stated to give excellent results in the treatment of poisoned wounds, snake-bites, insect stings, &c. Thuja is reputed to allay the pain, and promote the healing, of wounds and ulcers, and these properties have been turned to good account in gonorrhoea by using it as an injection.

Ecthol is a clear, brown fluid with an odour recalling that of valerian, and unquestionably possesses valuable sedative and antiseptic properties, rendering it useful in irritative dyspepsia, and, when applied externally, in cases of gonorrhoea, vaginitis, and erysipelas.

Medical News.

The Registration of Midwives.

COPY of a memorial addressed to the General Medical Council in May, 1899, by the Council of the British Gynaecological Society.—

"The Council of the British Gynaecological Society approach the General Medical Council with the view of securing on its part the fullest consideration of any proposed Bill dealing with the licensing of midwives, so as to prevent any direct or indirect infraction of the Medical Act of 1886.

"The Council, while recognising the necessity for such legislation as shall prevent incompetent women from acting as midwives or midwifery nurses, trusts that the General Medical Council will not lend its support to any Bill which does not adequately provide for the public safety nor protect the interests of the medical profession.

"The Council of the British Gynaecological Society would ask the General Medical Council to consider the many inherent difficulties which are inseparable from the recognition by the State of a new order of midwives, entitled by a registerable license to practice for gain, without direct medical control, the art of obstetrics.

"As one proof of the necessity for such deliberation on the part of the General Medical Council, the Council of the British Gynaecological Society would point to the obviously vague use of the term 'natural labour,' on the application of which term the entire construction of the present Bill is based.

"The Council regard it to be a function of the General Medical Council to take such measures as it may consider right to restrict the independent action of such midwifery or monthly nurses, in the conduct of parturition, as will prevent the assumption by them of those duties which rightly fall to the medical man alone to dis-

charge. Towards this end, the report of a sub-committee, as has been suggested by the direct representatives of the profession on the Medical Council, would appear to be both valuable and desirable.

"Without such limitations being imposed on women who are ignorant of all the collateral branches of medical science, on which the first principles of the obstetric art depend, and without any guarantee to insure a prompt appeal for medical supervision in the conduct of parturition when such is required from any cause whatsoever, the Council of the British Gynaecological Society views with concern the creation of a new and inferior grade of licensed practitioners.

"The extreme gravity of the question, and the influence which any legislation with regard to it must exert on the practice of obstetrics in this country, has induced the Council of the British Gynaecological Society, in the cause of medical science generally, and in defence of the art of midwifery in particular, to address the General Medical Council on the matter, and to respectfully ask its consideration of this Memorial."

Copy of the resolution adopted by the General Medical Council, with regard to the memorial of the British Gynaecological Society:—"That the memorial be acknowledged with thanks, and that the British Gynaecological Society be informed that the successive reports of the Committee to the Council will show that the considerations set forth in the Memorial have continually been kept in view by the Committee."

Chelsea Hospital for Women.

WE are asked to announce that the Chelsea Hospital for Women offers special facilities for the gratuitous treatment of wives of reservists suffering from diseases which come within its province. The annual general meeting of Governors of this institution will be held on Tuesday next at 3.30 p.m.

PASS LISTS.

Royal College of Surgeons in Ireland. Fellowship Examination.

MR. D. A. FITZGERALD having passed the necessary examination, has been admitted a Fellow of the College.

The following gentlemen have passed the primary part of this examination:—Mr. F. H. McC. C. Crawley, Mr. K. L. G. Gunn, Mr. S. H. Law, Mr. A. Charles, Mr. T. A. Dillon, and Mr. A. H. B. Hartford.

Apothecaries' Hall, Ireland.

THE following candidates have passed the under-mentioned professional examinations:—

Second Professional.—Richard Tracy, physiology and anatomy, H. W. Mason, anatomy.

Third Professional.—L. J. Farrell, pathology and hygiene and forensic medicine: S. Adye Curran, pathology and materia medica; J. D'Arcy Hamilton, pathology and forensic medicine: W. P. Harding, medicine and surgery; F. A. Bass, medicine and midwifery; A. J. Barnes, medicine, midwifery, and ophthalmic surgery; G. M. Sharpe, medicine, surgery, midwifery, and ophthalmology.

The following gentlemen have completed the final examination, and have been admitted licentiates of the Apothecaries' Hall, and are now qualified to practice medicine, surgery, and midwifery:—Frederick Ellis Bass, William Patrick Harding, and George Metcalfe Sharpe.

Society of Apothecaries of London.

DURING February Examinations the following candidates passed in:—

Surgery.—C. B. S. Ames (Sections I. and II.), C. A. W. Egan, W. J. H. Wepworth, O. E. Lemin (Section I.), R. V. A. Mosley (Sections I. and II.), S. Page (Section I.), A. Y. St. Leger (Section I.), N. Walmisley, A. J. Watson (Section I.)

Medicine.—C. B. S. Ames (Section II.), J. F. Hodgson, J. W. H. Morrison (Sections I. and II.), R. V. A. Mosley (Sections I. and II.), A. C. Oliver (Section I.)

Forensic Medicine.—J. F. Hodgson, J. W. H. Morrison, R. V. A. Mosley, A. C. Oliver.

Midwifery.—W. Alcock, C. E. C. Child, J. I. Halstead, J. F. Hodgson, G. J. W. Keigwin, A. E. Malaher, R. V. A. Mosley, E. A. Quirke, J. C. S. Rashleigh, M. J. Ryan.

The diploma of the Society (L.S.A. Lond.) was granted to the following candidates, entitling them to practice medicine, surgery, and midwifery:—C. B. S. Ames, C. A. W. Egan, W. J. H. Wepworth, R. V. A. Mosley, and N. Walmisley.

Notices to Correspondents, Short Letters, &c.

✉ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

MR. H. J. BROWN.—It may be so, but still the fact remains that urticaria may sometimes assume the hæmorrhagic form, and be attended with profuse hæmorrhage from mucous membranes. Why not call in a specialist in skin diseases? He would probably throw some light on the matter.

ETONENSIS.—The case you describe is undoubtedly one of Raynaud's disease. The symmetrical vasomotor disturbances and the myelitis and "blistering" of the finger tips constitute a group of symptoms that is quite typical. Raynaud's first description of the condition that now bears his name was made in a *Thesis* published in 1862. You will find all information as to this most interesting malady in an admirable monograph recently published by Dr. T. K. Munro, of Glasgow. There are many moot points as to the pathological and etiological relations of this condition, which is, perhaps, less rare than commonly supposed.

CIVIS.—Make a formal complaint to the Medical Officer of Health of your district. Your landlord is bound to keep the house in good sanitary repair.

L.R.C.P., M.R.C.S.—Certainly, we should regard any medical man who professed to treat primary syphilis without the aid of mercury as a charlatan. To order iodide of potassium for primary chancre is to proclaim the foolishness of the prescriber.

Meetings of the Societies and Lectures.

WEDNESDAY, FEBRUARY 28TH.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 p.m. Prof. A. Keith: The Results of an Investigation of the Anatomy of Man and Higher Primates to determine more accurately the Relationship of Man to Living and Extinct Forms.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY (West London Hospital, Hammersmith, W.).—Clinical Evening. The following Cases will be shown:—Mr. C. B. Keetley: (1) Radical Cure of Hernia ten years after Operation; (2) Case of Excision of the Pylorus.—Dr. C. Pope: (1) Case of Bradycardia in a Child; (2) Case of Abscess of Spleen cured by Drainage. Dr. S. Taylor: Case of Palsy of the Sixth, Seventh, and Eighth Cranial Nerves.—Dr. Abraham: Two Cases of Disease of the Skin.—Mr. Bidwell: (1) A Case of Nephrolithotomy; (2) Two Cases of Pyloroplasty.

LARYNGOLOGICAL SOCIETY OF LONDON (20, Hanover Square, W.).—5 p.m. Cases and Specimens will be shown by the following: Sir Felix Semon, Dr. Horne, Dr. Potter, Dr. F. well, Dr. St. Clair Thomson, Mr. Heath, Mr. Lake, Mr. Robinson, and Mr. Waggett.

WEST KENT MEDICO-CHIRURGICAL SOCIETY (Royal Kent Dispensary, Greenwich Road, S.E.).—8.45 p.m. Exhibition of Clinical Cases, Specimens, &c. (Living Cases will be shown first):—Dr. McCann and Dr. Ezard: Case of Ruptured Ovarian Cyst.—Dr. Adkins: A Case of Enteric Fever in which the whole of the Ulcers were transversely placed and Peyer's Patches not much affected.—Dr. Tootood: Cases from Lewisham Infirmary.—Mr. C. Williams: (1) Case of Caries of the Spine; (2) Cast, Specimen, and Skiagraph of Case of Congenital Hypertrophy of Great and Second Toes. Council Meeting.

SOCIETY OF ANÆSTHETISTS (20, Hanover Square, W.).—8.30 p.m. Adjourned Discussion on the After-Effects of Ether Inhalation on the Respiratory System (re-opened by Dr. Dudley Buxton).

DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND (20, Hanover Square, W.).—4.30 p.m. Informal Exhibition of Cases. 5 p.m., Ordinary Meeting.

THURSDAY, MARCH 1ST.

HOSPITAL FOR DISEASES OF THE NERVOUS SYSTEM (73, Welbeck Street).—At 5 p.m. Clinical Demonstration. Dr. Dundas Grant: Cases of Aural and other Forms of Vertigo.

THE RONTGEN SOCIETY (20, Hanover Square).—8 p.m. Paper by Mr. J. H. Gardiner, "Measurements of the Absorbability of Röntgen Rays." Dr. Hugh Walsham will show skiagrams of two Cases of Renal Calculus before and after removal.

FRIDAY, MARCH 2ND, 1900.

ROYAL ACADEMY OF MEDICINE OF IRELAND.—Section of Surgery. Business papers:—1. Mr. J. S. McArdle, on the Position of Murphy's Button in Modern Surgery; 2. Mr. J. F. Knott, on Dupuytren's Contraction of the Palmar Fascia; 3. Mr. E. H. Taylor on the Operative Treatment of Cleft Palate. Living Exhibits. Mr. John Lentaigne: Case of Double Perforation of Small Intestine in Sac of Femoral Hernia by Piece of Bacon Bone. Card Specimens: (a) Portion of Bacon Bone Producing Intestinal Perforation in Sac of Femoral Hernia. (b) Cancer of Penis with Lymphatic Glands.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 p.m. Prof. A. Keith: The Results of an Investigation of the Anatomy of Man and Higher Primates to determine more accurately the Relationship of Man to Living and Extinct Forms.

Appointments.

BATLISS, RICHARD ARTHUR, M.R.C.S., L.R.C.P.Lond., Honorary Medical Officer to the Eastern Dispensary, Bath.

BELL, H. J., L.R.C.P., L.R.C.S.Ed., Medical Officer for the Mortlake Sanitary District of the Richmond (Surrey) Union.

BROOKS, J. H., M.D.Aberd., Medical Superintendent of the Infirmary and Medical Officer of the Workhouse, Mile End, London.

GOFFE, E. G. L., M.B.Lond., L.R.C.P., M.R.C.S., Assistant Medical Superintendent to the Lewisham Infirmary.

OLIVER, A. R., M.B., C.M.Glasg., Surgeon to the Glasgow Central Dispensary.

ORR, VIVIAN B., M.B., B.S.Melb., L.R.C.P., M.R.C.S., Assistant House Surgeon to the Westminster Hospital.

RICHARDSON, W. G. M.B., B.S.Durh., F.R.C.S.Eng., Assistant Surgeon to the Royal Infirmary, Newcastle-on-Tyne.

SELBY, J. S. E., L.R.C.P.Lond., M.R.C.S., Medical Officer for the Seventh Sanitary District of the Aylesbury Union.

SMITH, Sir THOS., Bart., F.R.C.S.Eng., Honorary Consulting Surgeon to the Finsbury Dispensary, London, vice Sir James Paget, Bart., deceased.

Vacancies.

Abbeyleix Union.—Temporary Medical Officer. Salary £3 3s. per week. Immediate application to James Finnegan, Clerk of Union. (See Advt.)

Abbeyleix Union.—Permanent Medical Officer. Salary £100 per annum as Medical Officer, and £20 per annum as Sanitary Officer, with usual Vaccination Fees. Application to James Finnegan, Clerk of Union. (See Advt.)

Bradford Royal Infirmary.—House Surgeon, unmarried. Salary £110 per annum, with board and residence.

Carmarthen Infirmary.—Resident Medical Officer, unmarried, for twelve months. Salary £100 per annum, with furnished apartments, board attendance, fire, gas, and washing.

Castlereagh Union.—Trained Infirmary Nurse. Salary £50 per annum, with rations and apartments. Application to M. Flanagan, Clerk of the Union.

Consumption Hospital, Ventnor.—Assistant Resident Medical Officer to the Royal National Hospital for Consumption. Salary £100, with board and residence. Immediate application to Dr. Parry. (See Advt.)

County Borough of Southampton.—Assistant Medical Officer of Health, unmarried. Salary £150 per annum, with residence and board. Apply to the Town Clerk, Southampton.

County Borough of Stockport.—Medical Officer of Health for five years. Salary £400 per annum, increasing annually by £25 to £500. Apply to the Town Clerk, Town Clerk's Office, Stockport.

Cumberland and Westmorland Asylum, Garlands, Carlisle.—Junior Assistant Medical Officer, unmarried. Salary £100 a year, with board and residence.

Durham County Asylum.—Assistant Medical Officer. Salary, commencing at £141, with board, lodging, washing and attendance. Apply to Medical Superintendent, Winterton, Ferryhill.

General Hospital, Nottingham.—Assistant House Physician for twelve months. Salary £100, with board, lodging, and washing in the hospital.

Great Northern Central Hospital, Holloway, London.—Junior House Surgeon for six months. Salary at the rate of £8 per annum, with board, lodging, and washing in the hospital. (See Advt.)

KING'S College, London.—Senior Medical Registrar and Tutor and Senior Surgical Registrar and Tutor. Also Professorship of Materia Medica and Therapeutics.

Newport and Monmouthshire Hospital, Newport, Mon.—House Surgeon. Salary £100 per annum, with board and residence. No stimulants provided.

Queen's College, Cork.—Professorship of Materia Medica. Apply to the Under Secretary, Dublin Castle. (See Advt.)

St. Mary's Hospital School, Paddington, W.—Demonstrator of Physiology. Salary £100 to £150.

Workshop Dispensary Hospital.—Resident Surgeon. Salary £120 per annum. Rooms, coal, gas, furniture, and housekeeper provided. Apply to Mr. Charles A. Whall, Workshop.

Births.

DICKSON.—On Feb. 25th, at Seardsdale Villas, Kensington, the wife of T. Hugh Dickson, M.A., M.R., of a daughter.

FAGGE.—On Feb. 20th, at St. Thomas's Street, S.E., the wife of C. H. Fagge, M.S., F.R.C.S., of a daughter.

KEELE.—On Feb. 30th, at St. Paul's Road, Highbury, the wife of David Keele, M.R.C.S., L.R.C.P., of a son.

Marriages.

COBB—WALKER.—On Feb. 21st, at All Saints', Leamington, Ernest Herbert Cobb, M.R.C.S., L.R.C.P.Lond., elder son of James F. Cobb, Esq., of 5, Cornwall Terrace, London, to Eleanor, second daughter of the Rev. F. J. Walker, late Rector of Frodesley, Shropshire.

KEKWICK—PRAIN.—On Feb. 22nd, at Blackness House, Dundee, John Kekwick, M.R.C.S., L.R.C.P., L.D.S.Eng., to Catherine, eldest daughter of John Easton Prain, of Dundee.

ROWLAND PLUMER.—On Feb. 20th, at Shoreham, Walter John Rowland, B.A.Lond., M.B.Durh., M.R.C.S., L.R.C.P., son of John Rowland, of Gwydyr House, Bromley, Kent, to Jessie daughter of Alfred S. Plumer, of Springwells, Steyning, Sussex.

Deaths.

CARDOZO.—On Feb. 19th, 1900, in London, Samuel Cardozo, M.D., aged 77 years.

DAVIS.—On Feb. 18th, at his residence, Crawford Square, London-derry, Thomas Davis, M.D., J.F., aged 82 years.

HOLT.—On Feb. 21st, from wounds received in action with Sir Redvers Buller's force in Natal, E. H. E. G. Holt, Captain Royal Army Medical Corps, aged 33.

JONES.—On Feb. 20th, at Ladysmith, of enteric fever, G. W. G. Jones, Lieut., Royal Army Medical Corps, aged 25.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXX.

WEDNESDAY, MARCH 7, 1900.

No. 10.

The Lettsomian Lectures.

PRACTICAL OBSERVATIONS

ON

CANCER OF THE BREAST. (a)

By SIR WILLIAM M. BANKS, LL.D., F.R.C.S.

Surgeon to the Liverpool Royal Infirmary; Emeritus Professor of Anatomy in University College, Liverpool.

LECTURE I.

MR. PRESIDENT AND GENTLEMEN.—Naturally my first duty is to thank you for the honour you have done me in asking me to give the Lettsomian Lectures in the first year of the twentieth century. Let us fervently hope that long ere it has come to an end a remedy will be found for the fell scourge of which I propose to treat. I have in my consulting room the well-known engraving of the founders of this Society. I shall never look on the stiff but commanding figure of Quaker Lettsom as he stands in their midst without a feeling of pride that I have been permitted to be one of those privileged to assist in celebrating his name and fame. The roll of those who have delivered these lectures contains so many distinguished names that I may well feel some diffidence in trying to follow in their footsteps; but I take courage from the recollection that this is not the first time that the Medical Society has deputed me to address them.

EXPERIENCE AND STATISTICS IN MEDICINE.

When a man has to prepare an address the choice of a subject is generally a most difficult matter. If he has nothing of a very distinctly novel character to offer his hearers it is probably best for him to give them his experiences on the subject with which he is best acquainted. If he has any judgment and discretion in him he may do something useful in this way, because in our profession advances are so rapid that they are apt to become bewildering. The record of a long personal experience under such circumstances may be of service as a kind of steady medium. Moreover, these lectures, although nominally delivered to you, do really reach the majority of the medical public, and one of their prime uses is to present to that public at given periods a synoptical view of all that is known of the subjects they embrace up to the moment. I will endeavour then to put into them my experiences of cancer of the breast during the past 33 years in which I have been engaged in surgical practice. It is true that, in the absence of statistics, experience can only produce "impressions and recollections," and the professional statistician holds all "impressions and recollections" in the greatest contempt. He holds that figures can never lie. On the other hand it has long been painfully manifest that

nothing can be more lying and delusive than statistics if not properly used. In the first place their collection must be made with the utmost accuracy and with perfect purity of heart and calmness of mind. With medical statistics the temptation to gloss over and soften down unfavourable figures is very great, and requires that a man shall summon to his aid all his integrity. Again, when a man presents to you a vast mass of statistics, compiled at the expense of much time and labour, it is practically impossible to go over them with him, and you have no choice but to accept them. As a result many errors have been long handed down from book to book, until some disagreeable doubter has arisen who has exposed them. Finally, even when the statistics are absolutely correct, the most erroneous deductions may be drawn from them, and from the same figures two men may extract the most opposite conclusions. If anybody wants to know how statistics may be manipulated and applied let him consult the literature of the Anti-Contagious Diseases, Anti-vivisectionist and Anti-vaccinationist propaganda; all prepared by persons of the most superior virtue. Nobody wishes to deny to statistics their great value and their proper place, but one must also stand up for the value of those views which many successes and many failures have ingrained on the mind of any man endowed with an average amount of good sense and judgment. If, then, a man be not a waverer blown every way by the wind of opinion he ought, at the end of an experience extending over the life of a generation, to have come to certain firm and definite conclusions about many things, and if he proposes making these views public, he must express them in a firm and definite fashion. This necessarily exposes him to the charge of egotism and dogmatism. The former I shall endeavour to avoid as far as in me lies, but, should I occasionally become dogmatic, I pray you put it down to the exigencies of the situation, compelling me as they do to give my own particular views about cancer of the breast, while freely according to every other surgeon the liberty to advocate his views and declare mine entirely wrong.

THE INCREASE OF CANCEROUS DISEASE AND ITS CAUSE.

Before coming to cancer as it specially manifests itself in the female breast, I should like to say something on certain points on the general question of malignant disease, which legitimately forms part of our present subject. Most medical men are of opinion that the number of persons who die from cancer in proportion to the number of the population has been steadily increasing. Very voluminous statistics from the Registrar-General's returns and from the returns of deaths in individual towns and counties seem to prove this very emphatically. My own "impression," apart from any knowledge gained from statistics, is strongly to the same effect. It is true that the "impression" of a surgeon who sees a great deal of cancer must be received with care, for it is doubtless the case that,

(a) Delivered before the Medical Society of London, Monday, March 5th, 1900.

as a man's practice increases, he may see more of certain cases than he used to do, because his friends, knowing that he is interested in them, send them to him. Thus he may come to think that the same thing is happening in the practice of everybody, and that there is a general increase in those diseases all round, whereas the increase is in reality only in his own sphere of observation. In order to protect myself from falling into this mistake I have summoned up my recollection of the year 1861-2, when I was a dresser in the wards of Mr. Syme in the Edinburgh Royal Infirmary. Mr. Syme had a reputation then as indisputably the first surgeon in Scotland. So that, I am sure my old fellow-students of the period I mention will bear me out in saying that the pick of the surgical cases in the south of Scotland were sent to him. I have a very vivid recollection of the run of cases I saw, and possess a note book to-day containing many of them. Now cases of cancer, although not uncommon, were rare compared with the numbers in the practice of my colleagues at the Liverpool Royal Infirmary and myself at this moment. They were objects of curiosity and interest to us students. I can only remember once seeing a case of cancer of the rectum. So that I am able quite clearly, after an interval of eight and thirty years, to assert that the number of cases in the wards of any one of the surgeons of the Liverpool Royal Infirmary at this day is much larger than I can remember in the wards of so distinguished a man as Mr. Syme, who drew his patients from a great area. This is more than a mere impression. This is a fact. The arguments used against the alleged increase of cancer are that it is more apparent than real on account of the improved diagnosis of modern days producing greater accuracy in death certificates, and on account of autopsies being formerly the exception in hospital whereas they are now the rule. In his very able article in the *Practitioner* for April, 1899, Dr. Arthur Newsholme advocates these views with much ability. On these points I will, with your permission, gentlemen, once more revert to my student experience. I think it may be fairly admitted that the character of the medical teaching at any given epoch is a barometer which gives the level of the knowledge of the mass of practitioners at that same period. In 1861 Miller, Syme, Spence, and Patrick Watson were the chief surgical teachers in Edinburgh. I assert that their knowledge of surgical cancer on the surface of the body, and in the ends of the intestinal tract, was as accurate as that of any surgeon of the present day. Bennett, Laycock, Begbie, Gairdner, and Sanders taught medicine, and I am unable to see any notable difference between their ideas of internal cancer and their methods of diagnosing it as compared with now. If mention be made of the brain, spinal cord and nervous system generally, then, at the time I speak of, absolutely nothing was known about them, and the improvements in the diagnosis of them can only be appreciated by one who has witnessed the change. But this is not the case with the diagnosis of cancer. I do not like to say much about the increase in the number of autopsies at hospitals, because I cannot make a positive statement on the question beyond this, that in my student days at Edinburgh, and I imagine the same holds good of all the great London hospitals, every effort was made to secure post-mortem examinations when possible. One would too gladly wish that Dr. Newsholme were right, but immediately following his paper is one by Professor Boswell Bark, of Buffalo, who states that in England and Wales the cancer death-rate has risen from 1 out of 5,646 of population in 1840 to 1 out of every 1,306 of population in 1890; that is to say, that in fifty years the death-rate has increased between four and five times, and he makes this astonishing

statement: "A careful study of all these tables permits one to make the following startling prophecy. If for the next ten years the relative death-rates are maintained, we shall find that ten years from now, namely in 1909, there will be more deaths in New York State from cancer than from consumption, small-pox, and typhoid fever combined." With every wish, then, to give a good deal to the theory of better diagnosis and more numerous autopsies, I cannot bring myself to believe that they account for more than a moderate amount in the increase of cancer mortality.

LOCAL DISTRIBUTION.

Has locality anything to do with cancer? This is a matter upon which a great deal hinges, but from personal experience I cannot give any information. It is unlikely that any hospital surgeon will be able to do so, for he who has obtained any reputation for the operative treatment of cancer draws his patients from such varied sources that the question of locality as affecting them is void. On this subject information of any moment can only be obtained by collecting great masses of statistics, and even then the deductions therefrom will have to be made very cautiously and judiciously. The first attempt in this direction was made by Mr. Moore of the Middlesex Hospital, in 1865, and to him is also due the merit of being the first who boldly drew the attention of the profession to the inefficient operations for cancer which were performed in his day. To his courageous protest is due the modern principle of free removal. But, as we all know, Mr. Haviland's labours have been those of a lifetime, and his tables of statistics are a marvel. In 1868 to the Medical Society in this very room he read his first paper "On the Geographical Distribution of Cancer among Females throughout England and Wales the Decennial Period 1851-60." He found that 4.33 cases of cancer occurred in every 10,000 females, and 1.94 in every 10,000 males. Leaving untouched the decennial periods 1861-70 and 1871-80, he investigated 1881-90. He then found 7.30 cases in 10,000 females and 4.30 in 10,000 males; i.e., 0.42 more than double among males and 1.28 less than double among females. Admitting these statistics as true, two things are clear. 1. That there has been a great general increase of cancer all round. 2. That this increase is much more marked in males than in females.

The following are Mr. Haviland's "last words":—

1. That the districts having the *highest death-rates* from cancer among females were invariably associated with seasonally flooded areas traversed by, or in close proximity to, seasonally flooded rivers.

2. That geologically these *high mortality* districts were characterised by alluvium and subsoils of clays of every variety of age and formation.

3. That the districts having the *lowest death-rates* from cancer were situated on elevated land, where the drainage was good and the physical features of the country such as to preclude the possibility of floods; where rivers derived their sources and where, in fact, they are not fully formed.

(4) That geologically these *low mortality* districts were characterised by the eldest, palæozoic rocks, especially those of the carboniferous limestone periods, the liassic, oolitic, and cretaceous limestones.

The closing sentences of Mr. Haviland's intensely interesting paper run as follows:—"Thus at the end of this brief sketch of the medical geography of cancer we find ourselves asking the same question that rose to the lips of my audience in November, 1896: 'How is it that limestones are always associated in England and Wales with the *lowest* mortality from cancer, and *flooded clays* with the *highest*?' This question still remains unanswered, and will still so remain until the subject is taken up in earnest by the medical profession; for it is a field

I find after thirty years of working in it, that cannot be made to produce fruit without the toil of many labourers. When the above question is answered light will begin to fall on the cause of cancer.' It is a most refreshing thing to find this veteran statistician placing his figures at the disposal of his fellow-practitioners, modestly admitting his inability to draw sure and certain conclusions from them, and encouraging other workers to supplement his labours so that some determination on a most important question may be reached.

Let us turn to Mr. W. Roger Williams' most interesting work on "Diseases of the Breast," published in 1894, a work evincing an infinity of statistical learning. It is a model of how research by statistics should be employed in which figures are fairly handled and deductions prudently made. Furthermore, it is a mine for all those to dig in who are interested in the question of cancer. Mr. Williams thinks there is much to be said in favour of the opinion that in this country cancer is specially prevalent in flat, low-lying, fenny districts; noting especially Cambridgeshire and the adjacent counties of Northamptonshire, Huntingdonshire, and Bedfordshire. He observes, however (taking his figures from the Registrar-General's Forty-seventh Report), that all low-lying and seasonally flooded districts have not a high cancer mortality. The very large area drained by the Severn and its tributaries, for instance, has throughout a low average mortality from this disease. In fact, as we shall see presently, his view of the cause of the increased cancer mortality is very different and is not geological at all.

One would very much like to enter into the question of cancer houses, but it is, perhaps, digressing too far from my subject, which really has relation to the disease as it occurs in the breast. Mr. Haviland, Mr. D'Arcy Power, and Mr. Law Webb, of Ironbridge, in this country, as well as certain French and German surgeons, have written papers on the subject of profound interest—indeed, almost terrible interest. Still more evidence, however, will have to be forthcoming to make a clear case, for the liability to fallacious deduction in such a subject is so serious that a great mass and weight of testimony in its favour will yet have to be produced.

CAUSE OF THE INCREASED CANCER DEATH-RATE.

Up to the present time while statistics have already cleared and are at this moment rapidly clearing up many points about cancer, nothing definite has as yet been furnished by them as to the reason of its increase. That being so, there is a fair and reasonable ground for the employment of the "impression" begotten of experience. For many years the more I have thought over this matter the more forcibly does the idea present itself to me that it may be due to the great increase in the amount of food consumed by the people of this country during the past half-century. At all events, this view is worthy of being argued. I think it was first put into my head a long time ago by Sir James Paget. I took to him a lady with incurable cancer. He gave her some directions, and one was that she was to eat as little as possible—to try and starve herself, in fact. His long experience had taught him that to starve the body as a whole probably meant starving the cancer locally. *Per contra*, if that be a correct notion, then cancer ought to be connected with well-nourished bodies. Certain it is that the disease has not appeared to me to affect the weakling, the tea-shriveled, mummy-like old maid, or the ill-fed, more than half-starved drunkard, who never has any money to spend on good food. Its most numerous victims are well-nourished persons, with plenty of beef and fat about them, and often with a fine, healthy colour in their cheeks. In summing up the

many operations I have done for cancer of the tongue, my recollection of the patients is for the most part of biggish, powerful men with, large strong jaws which were hard to saw through when sawing had to be done. The better the nutrition and the younger the patient the more deadly and rapidly growing is the cancer. Take what is termed a fine, "buxom" woman of thirty or thirty-five with cancer of the breast, and her chance of permanent cure, even by the most extensive of operations, is almost *nil*. It is true that cancer is uncommon in the young during the period of development of the body and of the functional activity of organs, so that in one sense it is a disease of "degeneration," but this has nothing to do with the good nourishment and muscular development of the body in middle life. Being assured in one's own mind that well nourished, well developed, healthy people are the most numerous victims of cancer, the question at once arises, Is the increase of cancer in any way synchronous with an increase of nutrient material—i.e., of food—throughout the country, and are people in consequence better nourished? There cannot be a doubt of it. Ever since the passing of the Corn Laws bread has been cheap and plentiful, while during the last twenty years the importation of animal food from other countries has been enormous. The increased wages and emoluments of all classes in this country have enabled them to purchase freely of the best there is to be had in the whole world of things to eat and drink. Our working classes fare admirably. Our better classes eat infinitely too much, especially of animal food partaken of at breakfast, lunch, and dinner. But for the athletic tendency of the age and the general passion for games and exercises which pervades all classes, this over stuffing must have proved very dangerous. I am pretty well convinced that when a man is over five-and-forty excess in food is perhaps worse for him than excess in drink. Apparently one of the results of too much nourishing food is the production of a widely-spread, second rate kind of gout of a different type from the acute and furious attacks produced in former days by the copious drinking of beer and port wine. Moreover, I think distinctly that it has also to do with the production of the cancerous diathesis. This is also the opinion of Mr. Roger Williams, who, while admitting Mr. Haviland's topographical statistics, cannot agree with him in his geological views, but inclines to think that cancer areas are also the areas where the people are best nourished. The stock answer to what may be called the Over-nutrition Theory is that vegetarians and rice-eaters are just as subject to cancer as gross feeders and flesh-eaters, and this statement goes on being very steadily repeated from one book to another. I am not prepared to admit this. Cancer is not so rife in Ireland, where feeding has been poor and very largely of a vegetable character, and where improvement in the living of the people has not proceeded *pari passu* with that in England. The Registrar-General's Report for the decade 1881-90 shows that in 1881 in England 1 death in 36 was due to cancer, and in Ireland 1 in 47, while in 1890 in England there was 1 in 28, and in Ireland 1 in 40. Ireland, therefore, does not rise to the level of England. Mr. Roger Williams has a most interesting chapter of facts in this connection. He tells that Billings, of the United States, showed that among the whites there were two cases to one among the blacks. From what can be learnt of the whole continent of Africa, that vast country enjoys a remarkable immunity from the disease, especially the Egyptian area and the Northern parts. At the Cape, cancer is common among the whites, but very rare among the natives. All through the tropics the disease is distinctly rare. In India the general opinion is that it is not common, and

that when it does occur neither the rice-eaters nor the meat-eaters are exempt. It is true that certain surgeons (McLeod, Hendley, and Lawrie notably) hold the opposite opinion, but I notice that their experiences are drawn from hospital work almost entirely, and refer chiefly to the number of operations occurring in large hospitals. This seems hardly a sound argument. All that it proves is that a number of cases of cancer come into large hospitals and consequently that in a huge country there must be many cases of cancer. But, if statistics are to be of any avail, the proportion of cases to the actual population is absolutely necessary to make any fair deduction. It is like the death rate from snake-bite. To an Englishman who never sees such a thing the sum total of these seems appalling. It is not till one takes the proportion to the astounding population of India that the insignificance of the loss of life becomes apparent. If there were no knowledge of the exact population of Lancashire, and if a person were to walk round the wards of the Liverpool Royal Infirmary and estimate the cancer mortality of the county from the number of cases found in these wards, his view of the prevalence of the disease would be a most alarming one.

At this moment the Massachusetts State Board of Health is instituting an inquiry into this question. Its circular states that "Every year there is an increase in the reports to the State of the number of deaths from cancer, even when allowance is made for age and greater population. By some it is alleged that this is due to an increase of the disease itself; by others that better diagnosis and more careful registration will account for it. Furthermore, the infectious nature of this disease, caused by a possible parasite, and its contagiousness have been strongly urged." I believe that the great general increase of cancer is for the most part admitted, and that Dr. Newsholme's idea that it is not real but only an apparent increase, due to better knowledge and more accurate registration of the disease, is entirely erroneous. But, even were we to admit his views, it would not account for the fact that, during the past thirty years, the comparative cancer mortality of the sexes has altered in a most singular manner, so that whereas the disease was formerly more prevalent among females, it has now become more prevalent among males, and is becoming increasingly so.

Now, do drunken habits account for more cancer?

I am certain that confirmed drunkards are not more liable to it than other people. Besides, drunken habits are rather diminishing than increasing. Does syphilis account for it? I have never been able to trace any connection between that disease and cancer whatever. It is true that leukoplakial bald patches and specific surface ulcers of the tongue and mouth are places where epithelial cancers arise, but they do so, not in virtue of any special syphilitic taint, but just as they arise from irritation of any kind, as from a sharp-edged tooth. Mr. Williams, out of 165 female breast-cancer patients, did not find a single one of immoral character. Do bad water, bad housing, and bad sanitary arrangements account for it? This is impossible, for in nothing have we improved so much as in improved sanitation; in improved water supply, drainage, housing, and clothing. Will increased nervous tension from our rapid existence, due to the development of steam and electricity, account for it? It would seem reasonable to suppose this likely to produce all sorts of nervous troubles and arterial or cardiac degenerations, but not cancer. Is it due to the fact that there is a great saving in the early periods of life, and that more people live into what may be called the cancerous age? The Registrar-General's statistics show that the number of persons of twenty-five years of age and upwards, out of every million living persons, was just the same in the

decade 1881-90 as in the decade 1871-80. There has, therefore, been no increase in the proportion of persons who live into the cancerous age.

What great change, then, has taken place in the national life? Richer and more abundant food. You will note particularly that it is the male who eats the heavy food in ever-increasing quantities, while the female remains much as before in her eating, and note along with this that it is men now who suffer most severely from cancer, and not women as formerly. Again, in all England the most tainted places are London, the Thames Valley, and the counties adjoining the metropolis, where the most luxurious habits and the best living prevail, and it has been pointed out that, even in the capital itself, the parts where those in easy, comfortable circumstances, who are supplied with more than the necessities of life abide, show the highest mortality. It is curious to note that amongst the very highest mortality rates for occupations are those which include commercial travellers, coachmen and grooms, merchant seamen, maltsters, brewers, innkeepers, butchers, and plumbers. Most of these certainly are persons likely to eat and drink abundantly, and not take too much exercise—persons who live well and don't work off their spare products. Singularly enough, doctors figure low in the list.

In conclusion, let me quote Mr. Moore's statement, made many years ago, that "cancer is eminently a disease of persons whose previous life has been healthy, and whose nutritive vigour gives them otherwise a prospect of long life."

(To be continued.)

THE CAUSES AND TREATMENT OF MOVABLE KIDNEY. (a)

By MANSELL MOULLIN, M.D. Oxon., F.R.C.S.,
Surgeon and Lecturer on Surgery at the London Hospital

AFTER thanking the President and the Fellows of the Hunterian Society for inviting him to deliver one of the Hunterian lectures this year, and mentioning his reason for selecting movable kidney as his subject, the lecturer proceeded to explain why the presence of a movable kidney was so often diagnosed during life, and so rarely found after death. A distinction was drawn between movable kidney and floating kidney, in which there is a live mesonephron; and it was pointed out that although the kidney might push the peritoneum in front of it like a hernial sac, or even possibly insinuate itself between the layers of the ascending or the transverse mesocolon, neither of these could be regarded as constituting a mesonephron, a structure which it was almost impossible to explain on the ordinary view of the development of the peritoneum. The relation of the kidneys to Cunningham's subcostal plane was then described, and the lecturer proceeded to demonstrate that the generally accepted view that the kidneys were fixed organs was incorrect. During life the kidneys, with all their anatomical relations undisturbed, normally possess a range of movement estimated by Alberran at from three to five centimetres. The movement is especially evident when the kidney is exposed through an incision in the loin. This makes it more difficult to define what should be called a movable kidney. Kendal Franks holds that the extent of surface which can be felt beneath the ribs is the best criterion. A much more satisfactory test, however, is the failure of the kidney to reascend on tranquil expiration (coughing or straining is not fair) when the patient is

(a) Abstract of the Hunterian Lecture delivered before the Hunterian Society, February 24th, 1900.

standing erect, and has driven the kidney down by forced inspiration. I look upon this as sufficient, even if the kidney only comes down low enough to enable its inferior extremity to be felt. If, on the other hand, it retains its normal relation to the diaphragm, so that the movement of the one follows that of the other, I do not regard it as unduly movable, even if half of the organ can be felt.

The kidneys are invested by what has been described by Luckerbendl and Gerote as the perirenal fascia. This is a development of the subperitoneal tissue, strengthened upon the left side, where it lies upon the ventral surface of the kidney, by some fibrous bands, which Luckerbendl has shown to be the remnant of the fusion of the descending mesocolon with a primitive parietal peritoneum. The corresponding strands on the right side, owing to the different position of the colon, stand in no relation to the kidney. The fascia consists of two layers, anterior and posterior. These are united along the external convex border of the kidney, but are quite separate on the inner side and below. The anterior layer passes across the great vessels, and becomes continuous with the anterior layer of the opposite side. Below, both layers are lost in the subperitoneal tissue. Together they form an investment for the kidney, loosely attached to it by connective tissue and fat, open on the inner side and below. Like the recess in which the kidney lies, this fascia offers no resistance to movement of the kidney downward and inwards. The normal movements of the kidney during respiration, and when the body is raised from a horizontal to an erect position, take place inside this investing fascia.

Immediately around the kidneys, inside this perirenal fascia, is a large amount of fat which differs in colour and consistence from the ordinary subperitoneal fat, and which must be regarded to some extent as a special structure having a special function. It is but slightly developed until the eighth or tenth year, and is so soft and delicate in structure that it appears to be much more suited to facilitate the movements of the kidney than to check them. This deposit is especially thick in the posterior surface, and opposite the hilus, for on this surface the perirenal fascia is closely attached to the transversalis fascia, and this in its turn is firmly blended with the muscles beneath. In front there is comparatively little, for here the anterior layer is more loosely attached to the peritoneum, and both are movable. Atrophy of this fat has been noted in some cases of movable kidney, but much more often is abundantly developed, and has to be stripped off in the operation for suturing the kidney in place.

Running through this fat are some stouter strands of fibrous issue, which pass from the fascia to the renal capsule. They are best developed above, and opposite the hilus, but there are a few below. In cases of nephroptosis these are either torn or unduly stretched. Wolbon and Delitzin have shown that they are not strong enough to support the weight of the kidney, and they believe that their chief function is to maintain the normal shape of the kidney, and the relative position of its different parts. If the upper ones are divided, the upper segment of the kidney, according to these observers, falls forwards upon the lower. Potain has described this displacement, which he calls anteversion of the kidney, and it is said that sometimes it causes very severe symptoms, from the way in which it presses upon the neck of the gall-bladder and the bile-duct. However this may be, Newman showed a long while ago that if the abdomen is opened while the body is suspended in the erect position, the kidneys, which are already at their lowest normal point, fall much lower, even though these bands are uncut. Neither the fascia nor the fat is capable of

maintaining the kidney in position when the influence of the abdominal pressure is removed.

The same may be said of the peritoneum. This is stronger on the right side than the left, owing to a special fold described by Jonnesco; but the kidneys glide behind it, and it is so easily displaced, even on the posterior wall of the abdomen, that they have no difficulty in pushing it before them. The surrounding organs check the movements of the kidneys and support them, but the kidneys are not in any way tied down or fastened by ligaments, like, for instance, the splenic flexure of the colon.

Kendal Franks described the kidneys as maintained in position by the combined pressure of the liver, acting from above and in front, and the colon, acting from below and in front. But the liver and the colon, so far as intra-abdominal pressure is concerned, cannot be regarded as independent agents. Together with all the other organs enclosed by the peritoneum, they form one soft elastic mass pressing against the kidneys. If any one of the organs that form this mass changes in position or consistence, the rest, so long as the peritoneal cavity is unopened, compensate for it at once. There is no independent action until air has been admitted into the peritoneal cavity.

Glénard regards mobility of the kidneys as merely one of the phenomena of enteroptosis; but in the vast majority of cases in which the right kidney is movable there is no displacement of the other viscera. When enteroptosis does occur, so that the liver rotates and the intestines sink, movable kidney may follow, owing to the disturbance of the intra-abdominal pressure. Even this, however, will only happen if there is at the same time defective development of the lumbar recesses.

The kidneys are maintained in position partly by the pressure in the intra-peritoneal space, partly by the way in which they fit into the lumbar recesses. Neither of these is sufficient without the other. Woldon and Delitzin in particular have drawn attention to the importance of the shape of the lumbar recesses. This is best shown by taking plaster casts of the posterior wall of the abdomen while the body is suspended vertically. In the male they are deep, narrow, and pear-shaped, with the narrow end below. In the female, owing to the greater width of the pelvis, they are shallow and more cylindrical, and the difference in shape is almost always more marked upon the right side than upon the left. This I believe to be due to a slight degree of torsion of the lumbar spine. In right-handed people there is usually a slight convexity towards the right in the dorsal spine. This entails an equivalent convexity towards the left in the lumbar region; and this, in its turn, necessitates a slight degree of rotation. The left transverse processes rotate backwards, and deepen the lumbar recess upon that side. The right rotate forwards, and make the lumbar recess proportionately more shallow.

In a very large number of cases of movable kidney there is definite flattening of the right lumbar region. This, of course, cannot possibly be due to absence of the right kidney. Abdominal nephrectomy does not cause it. It really means that the vertebrae have rotated slightly, and is an indication of the cause of the displacement of the kidney, not a consequence of it.

The width of the lumbar recesses is one of the penalties which have followed the assumption of the erect attitude. If the history of the development of the renal organs in the race, as well as in the individual, is worked out, it is seen that originally they were distributed over the whole length of the head and body; and that by degrees, as their function became more specialised, they became concentrated together, until in their most perfect form they con-

stitute a pair of organs, which, in the quadrupedal mammal, are placed in a position of the greatest possible security. They lie close to the spine immediately under the antecentral vertebræ, almost in the central axis, around which all movement of the trunk and limbs takes place. They are buried in two deep and narrow recesses, protected by the lower ribs, and resting upon a horizontal sheet of fascia, which in its turn rests upon the peritoneal viscera. The slight degree of backward and forward movement which is necessitated by the action of the diaphragm, takes place without the least risk. But with the assumption of the erect attitude the greater portion of this security is lost. The backward and forward movement is altered to movement upwards and downwards, in the direction of the line of gravity. The peritoneal viscera and the supporting fascia lie in front, and not below. The lumbar recesses, instead of being deep and narrow, become broad. The convexity forwards of the lumbar spine helps to make them still more shallow. The pelvis, especially in the female sex, becomes wider, so that the lower end of the recess becomes more open; and then the development of right-handedness causes the transverse processes of the lumbar vertebræ, which lie under the floor of the lumbar recess, to rotate ever so little. From a position of the greatest safety, the kidneys are placed in one from which all security is gone; and it is not to be wondered at that comparatively trivial causes—an increase in the weight of the organ without a corresponding increase in the bulk, a sudden violent jerk, or a great lowering of the intra-abdominal pressure—can increase their normal range of mobility. The wonder is, not that movable kidney occurs, but that it does not occur more often.

This will account completely for the peculiar clinical distribution of movable kidney. It is certainly hereditary, and common. It is present in women much more often than it is in men; and in women who have borne children more often than in those who have not. And it is much more common upon the right side than upon the left. None of the other reasons which have been assigned for this, such as the weight of the liver or the length of the renal vessels, deserve consideration.

(The lecturer, after detailing the different methods of treatment which have been advised, proceeded.)

The choice lies between wearing an abdominal belt and nephrorrhaphy. In my experience it is only in the milder cases that the former succeeds, and then it must be combined with massage and exercises calculated to strengthen the abdominal muscles. A belt braces the viscera together, and so steadies the displaced organ, but it cannot press the kidney back into its place, or retain it there after it has been reduced, if the patient stands upright and takes a deep breath.

Pads are useless. For all cases in which there is manifest deformity of the lumbar region associated with movable kidney, or in which there is real distress, even if the mobility strains no higher degree than the anteversion of Potain, I never hesitate to recommend nephrorrhaphy. In the former case it is advisable in order to save the kidney from hydro-nephrosis and other troubles. In the latter I believe it to be the most certain method of giving relief. I have never known it fail when properly carried out, if the symptoms have not already lasted so long as to produce an indelible impression upon the patient's nervous system.

The second reading of the Bill for the Registration of Midwives, which was down on the list for Wednesday last, was not reached.

THE SURGICAL TREATMENT OF TUBERCULOUS KIDNEY.

By DR. KÖNIG,
of Berlin.

A FEW decenniums ago the subject of tubercle of the kidneys was almost unknown, and it hardly ever occurred to the surgeon to consider the matter, only tubercle of the bladder being thought worthy of special attention. Once, however, it had been recognised that so-called catarrhs of the bladder were frequently tuberculous, it gradually came to be understood that these vesical catarrhs were in reality tubercle of the kidney. An unprejudiced consideration of the question dates from Simon's investigations, and these showed that only a small quantity of functionally active kidney substance was necessary for the maintenance of life. It was only from this period that operation could be thought of. But the idea of removing tuberculous kidneys was not at first grasped, and when this came to pass it was generally the result of an error of diagnosis. In the commencement of the eighties, however, tuberculous kidneys were deliberately removed, and in 1883-84 statistics on the subject were published.

In renal tuberculosis two different conditions must be carefully distinguished. In the one form isolated foci of disease are found in the gland substance, either near the cortex or nearer the pelvis, but not communicating with the latter. As a rule there are one, two, or three patches with a tendency to caseation, or to the formation of phthisical cavities. The second form is the pyelitic, arising from the bursting of the glandular form into the pelvis of the kidney, or from an ascending tuberculosis. These two forms present very different symptoms. The first, the so-called hæmatogenous form (although it is not really known whether it is hæmatogenous or urogenous), is difficult of diagnosis, and can but rarely be controlled. In two of the speaker's cases it passed into the pyelitic form, in one case after gonococcal infection, the other in consequence of renal irritation set up by inhalation of turpentine. The first form had, therefore, a more theoretical interest. The assemblage of symptoms of tuberculous pyelitis is characteristic even without proof of the tubercle bacillus, which indeed it is not always possible to obtain. The symptoms indeed are those of chronic catarrh of the bladder, with certain peculiarities: gradual illness, with turbid urine, almost always frequent desire to micturate with pain in the urethra. If to these is added the typical kidney pain, of variable intensity and form, the diagnosis is tolerably certain. The diagnosis may be determined from the urine also; it is turbid, the sediment contains epithelium partly from the pelvis of the kidney and pus. Blood in every form is quite common, and it sometimes happens that the quantity is considerable, amounting to absolute flooding, especially at the commencement of the disease; often, especially in women, the kidney tumour can be felt. This group of symptoms justifies a diagnosis of tuberculous kidney, even when the bacilli cannot be detected. As a matter of fact they are only rarely to be found. Later on the bladder symptom becomes more pronounced owing to the presence of ulcerations, which, associated with swellings at the opening of the ureters, can often be seen. The patients are emaciated and feeble, and are markedly anæmic.

Medicines obviously cannot effect a cure. At one time the idea of extirpating the tuberculous disease alone was put forward. Max Wolff had recommended resection of the kidney, but practical experience was wanting. Out of seventeen kidneys extirpated there

was not one in which resection was possible, there was everywhere disease, and the pyelitis so bad that there could be no question of resection. Exploratory incisions might certainly be made in the kidney, and pieces might be excised without endangering life; but simple incision of the kidney and its pelvis, as recommended by Guyon can do no good.

The only possible operation is the extirpation of the diseased organ in its entirety. Of course the other kidney must be present, and by careful examination this can be determined. In the horseshoe kidney we have only one kidney, but as a rule it cannot be palpated, and it does not play the part of a solitary kidney. In the case of a boy the author had removed one part and the boy recovered. The solitary kidney is more difficult of diagnosis. With regard to this we have the following indications:—(1) The testicle is often absent on one side. (2) On cystoscopic examination if only one ureter is found there is but one kidney. Then, again, the healthiness of the other kidney is a difficult question. It has first to be decided which kidney is diseased, and this is shown by observing the flow of turbid urine out of a ureter. The cystoscope is not of such value as regards the second kidney, for it can only show that clear urine comes from the corresponding ureter, and that is not a certain proof that the organ is healthy. Even catheterisation of the ureter does not afford certain proof, as was shown by an error into which the master of catheterisation fell. Besides, the operation is not free from danger, for it may set up ascending tuberculosis. In short, there are no certain means of diagnosing whether the second kidney is or is not healthy.

In twenty of the author's own cases there had been an error of diagnosis in two. In one case the pyelitis was simple, although the lungs were tuberculous, and in the other smegma bacilli led to the error. Three cases died of uræmia. One was a case of caseous atrophic kidney, and in the other two there was necrosis of the epithelium, caused by chemicals, chloroform, or sublimate. No such cases occurred later on.

Another question arises: Can we operate when the other kidney is diseased? According to Tuffier's experiments the question can be answered in the affirmative. Simultaneous disease of the bladder, the testicles, or prostate is not a contra-indication. In deciding whether to operate or not we must always bear in mind that the patient's condition is so pitiable that he cannot last many weeks without operation, and we must risk something.

He had operated on eighteen cases, twelve women and six men, of whom three died in connection with the operation, three of continuing general tuberculosis three to nine weeks after operation, eleven recovered, and one case was too recent to consider. One was operated on in 1883, was quite healthy, and was about to marry. The second, a girl operated on nine years ago, was now a blooming (*blühendes*) maiden. The third was a labourer, operated on six years ago, was now so well that his sick pay had been withdrawn. Three other cases had been operated on two to two and a-half years (two of them were shown, and also a young woman and a young man operated on about a year). One girl with disease of the bladder as well and advanced kidney disease got quite well, and lived seven years, dying in childhood. Some of the cases recovered perfect, or at least comparatively good health, being rescued by the operation from almost certain and speedy death.

From his own observations the speaker summed up as follows:—1, Localised tuberculosis of the kidney can rarely be recognised; 2, tuberculous pyelitis on the contrary always; 3, absolute certainty that the other kidney is healthy cannot be obtained, but we

are still compelled to operate; 4, resection can only exceptionally be resorted to, extirpation being the normal operation, since it brings about a cure in a number of patients, and in many others prolongs life if nothing more.

NOTES FROM CURRENT MEDICAL LITERATURE.

FORMALIN AS AN APPLICATION TO CANCEROUS ULCERS.

DR. A. RAVOGLI reports wonderfully good results (*Virg. Med. Monthly*) following the use of a five per cent. solution of formalin to cancerous and rodent ulcers. Formalin has been gradually more and more used in surgical practice since its introduction in 1886. It is, however, a painful application, and before being applied to ulcers some local anæsthetic should be used on the part.

MENORRHAGIA.

Novo. Montcell. Med. recommends the following:—

Salpirine,	10 grammes;
Potass. Bromide,	10 grammes;
Ext. flu. Viburn. Pum.,	20 grammes;
Distilled Water,	120 grammes;
Cognac Brandy,	20 grammes;
Syrup of orange peel,	20 grammes.

Mix. One teaspoonful for a dose. The mixture is to be commenced five days prior to the change. On the fifth day prior to the change, a dose is to be taken at night; on the fourth and third days a dose is to be given night and morning; the second day a dose is to be taken morning, midday, and evening; and on the following three days a dose is to be taken four times each day.

TROPICAL DYSENTERY.

Decoction of Simaruba,	170 grammes;
Cognac Brandy,	10 grammes;
Mucilage of Salep,	10 grammes;
Tincture of Opium,	1 grumme;
Syrup of Orange Peel,	25 grammes.

Mix. One tablespoonful every two hours.—*La Semaine Médica.*

JANOCOL.

Janocol is a combination of gelatine and tannin. It occurs as a grey powder, odourless, tasteless, and almost insoluble in water, and sparingly soluble in dilute acids. Alkaline solutions dissolve it readily. Intestinal juice dissolves and decomposes it, liberating tannic acid. It is recommended as an astringent in acute and chronic enteritis, and in intestinal diseases of children.—*La Semaine Médica.*

PRURITUS.

Dr. Castel (*Gaz. Med. de Strasbourg*) refers to the good results he got in cases of pruritus from the use of lactic acid, in doses of from six to twenty drops twice a day. The effect is equally good in those cases of eczema of the buttocks occurring in young children with diarrhoea. With the lactic acid in cases of eczematous troubles he uses the following ointment:—

Salicylate of Methyl,	2 grammes;
Oxide of Zinc,	20 grammes;
Vaseline,	20 grammes.

Mix.

KINEWINE.

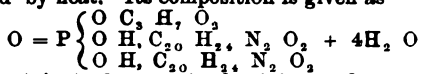
Kinewine (*La Progrès Médical*) is the name given by M. Moncom to the glycerophosphate of quinine which he introduced to La Société de Pharmacie.

It is obtained by neutralising the acid glycerophosphoric by quinine, by mixing and mutually decomposing a solution of a salt of quinine and the glycerophosphate of lime. The quinine salt occurs in fine needle-like colourless crystals; it is odourless; bitter, but its bitterness is less than that of quinine sulphate and more agreeable.

Kinewine is slightly soluble in water, more so in boiling water than cold. At a temperature of 15 degs. C. water dissolves one-half per cent. and one-and-a-half per

cent. at 100 degs. C. It is soluble in cold and boiling alcohol, insoluble in ether, and freely soluble in glycerine.

The salt is very stable remaining unchanged in the presence of the glycerophosphate of lime, and is not altered by heat. Its composition is given as



It contains 72.6 per cent. of quinine, and 19.2 per cent. of acid glycerophosphoric.

The therapeutic study of the chemical, made by M. Gilbert, shows that the new compound is equally good as a febrifuge as the sulphate of quinine, and that it is more easily assimilated, and having the same richness as quinine it is prescribed in the same doses.

DIABETIC FOOD.

In a long article (*Bull. Gen. de Therap.*), M. Mossé, professor of clinical medicine at Toulouse, concludes that in the diabetes of medium severity, particularly if associated with joint troubles, bread made of potato flour is much more suitable than bread made of wheat or other cereals.

JAUNDICE.

M. M. Lenez and Schneider publish (*Le Progrès Medical*) the case of an active attack of jaundice, marked by coma, convulsions, and scanty urine, which they treated with large injections of artificial serum, which they sent into the cellular tissue of the right iliac fossa, and repeated the injection in six hours.

A few hours afterwards the convulsions ceased, consciousness returned, and the patient had a copious flow of water and a brisk purging. The following day the injections were repeated, and some days afterwards the patient left hospital quite well.

TUBERCULOUS LARYNGITIS.

M. Lacroix, at a meeting of the Academy of Medicine, Paris, reports favourably of the use of antiseptic inhalations in cases of tuberculous laryngitis. He vapourises a mixture of menthol, bromoform, and formaldehyde. He has found the inhalations to have not only a soothing effect and to diminish the blood-shotness of the mucous membrane, but also to cause the healing of ulcers.

He bases his conclusions on an experience of three years.—*Le Progrès Medical*.

INITIAL TUBERCULOSIS OF THE RECTUM.

In a paper read before the Clinical Society of Maryland, Dr. Earle (*Vir. Med. Sem. M*) reports three cases of acute tuberculous proctitis studied at autopsy at Bay View. He found the bacilli in the infiltrated mucous membrane, where there was as yet no breaking down, and where the small cell infiltration was the only pathological condition.

RUPTURE OF THE URETER.

Le Progrès Medical reports the case of a man, 18 years old, who got a blow in the left side of the abdomen. One month after the accident the left side of the abdomen became much larger than the right, the increase in size was due to a collection of fluid which extended from Poupart's ligament to the fourth intercostal space. In the interval of a month and a half the collection of fluid was aspirated six times, and thirteen litres, and eight hundred grammes of fluid drawn off. The patient made a good recovery.

BISMARCK'S BRAIN.

The cerebrum of Prince Bismarck is said (*Rev. de Ther. Medicales*) to have weighed 1,807 grammes. The average weight of the European brain varies from 1,350 to 1,400 grammes. Of illustrious men whose cerebrums were weighed we find that of Dante to weigh 1,470 grammes, Schiller's weighed 1,596, Kant's 1,624, Byron's 1,792, and Cuvier's 1,828. On the other hand the brain of Gambetta was not above the average weight, and that of Shelley was distinctly below it.

Brains may, however, be so warped by hereditary influence or other, that the possessor gains notoriety

from crime only. Of such was Vacher, who assassinated some nineteen persons, and was guillotined on the 31st of December, 1898. His brain weighed 1,500 grammes, and the cerebellum 76 grammes; withal the great weight of evidence favours Dr. Marro's views: that incendiaries and murderers yield the largest proportion of individuals with defective intelligence.

Like the savage, the criminal is lacking in curiosity, the foundation of sciences, and one of the very highest acquisitions of man.

Clinical Records.

SOME SURGICAL CASES ILLUSTRATED BY RADIOGRAPHS. (a)

By NOBLE SMITH, F.R.C.S.Ed.

I AM enabled to lay before you some instances of the advantages of radiography in surgery. The first case is one of Potts fracture. Nine months after the accident the patient was hardly able to get about. A radiograph shows that the foot was so much displaced outwards that the weight of the body was transmitted through the centre of the tibia and impinged upon the inner edge of the astragalus, thus pushing the foot towards a valgus position.

The fibula, which had been fractured diagonally, had united with much thickening, making it impossible to replace the foot in a better position without operation.

The fibula was then cut through with a chisel, and the tendo Achillis divided, when the foot was easily placed in a much better position. The patient felt immediate relief from the aching she had previously suffered. A week after the operation movements of the joint and massage were commenced, and this treatment gave the patient great comfort. A few days later, she was able to stand up on the lame foot without difficulty. At the end of six weeks she was able to walk about far more comfortably than she had previously been able to since the accident. It is doubtful if this operation could have been carried out so successfully without the radiograph.

The next case is of a child, $\text{æt. } 2\frac{1}{2}$, who was thought to be affected with a bowed leg. I noted, however, that one leg only was affected, and that the inner malleolus was distinctly higher than natural, and that the child evinced pain upon interference with the limb. I therefore suggested a radiograph. This showed clearly a fracture of the tibia $1\frac{1}{2}$ ins. above the ankle-joint. It was cut down and the bone straightened, and the child made a good recovery.

I have also derived considerably assistance from radiographs of congenital dislocation of the hips, coxa vara, and knock-knees.

Dislocation of Cervical Vertebrae.—The following is a very interesting radiograph of the case of a lady who fell 80 ft. down some rocks in the Island of Sark, and although she was not killed she sustained a very severe shock and great bruising as well as severe cuts, the nose and one ear being much damaged. After some weeks' rest she began to get about again, and then suffered from pain and stiffness in her neck; also attacks of giddiness came on and so affected her that she would suddenly fall down, and especially when she placed her hands above her head in attempting to dress her hair. Upon examination of the spinal processes of the cervical vertebrae I detected an angular bend centred between the fifth and sixth cervical vertebrae. A radiograph clearly indicated a partial displacement between these two vertebrae. The patient was placed under ether, and firm extension made upon the head. Some adhesions were at first felt to give way, and after more force had been applied a slight gliding movement was felt in the neck. It was then found that the vertebrae occupied their natural straight position. The acute symptoms of the displacement have not been felt since the operation, and her mother has written to say that her daughter is now practically quite well.

(a) Read before the Windsor Medical Society.

Transactions of Societies.

ROYAL ACADEMY OF MEDICINE IN IRELAND SECTION OF ANATOMY AND PHYSIOLOGY.

MEETING HELD FRIDAY, FEBRUARY 2ND, 1900.

The President, Professor W. H. THOMPSON, M.D., in the Chair.

PROTAMINES AND THEIR CLEAVAGE PRODUCTS.

The President read a paper on Protamines, which or hydrolytic cleavage yield mainly hexone bases—viz. arginine, with histidin and lysine in some cases, and gave the result of experiments on anaesthetised dogs.

Prof. Coffey, Dr. W. Smith, and Dr. Dawson discussed this highly technical subject, and the President replied.

MODEL OF THORACIC AND ABDOMINAL VISCERA.

Dr. PATTEN, in the unavoidable absence of Professor Cunningham, exhibited for him a model of the thoracic and abdominal viscera from behind, which had been prepared primarily to exhibit the form and relations of the spleen.

SIMPLE FORMS OF MUCOUS GROWTH.

Professor COFFEY showed sections to illustrate the formation and manner of development of the small racemose glands of mucous membranes taken from the oesophagus of snakes.

A SERIES OF HUMAN EPIPHYSES.

Dr. KNOTT exhibited a large series of human bones, all of which presented non united or partially united epiphyses. The series illustrated the development of the limb bones, the pelvis, scapula, sternum, clavicle, metacarpals, metatarsals, phalanges, vertebrae, ribs, and a large number of cranial bones. Among the specially interesting items were an atlas which was obtained in process of ossification from at least nine centres, and an ulna which presented a small epiphysis on top of the ordinary epiphysis for the upper end of the olecranon process, a centre of ossification which, up to this, seems to have completely escaped the notice of anatomists. When the elbow-joint was bent this supernumerary epiphysis presented a striking resemblance to a diminutive patella turned upside down.

Professor BIRMINGHAM referred to the great difficulty of procuring specimens to show the epiphyses, and said he was not satisfied that the additional centre for the olecranon was constant.

THE FORM AND POSITION OF THE STOMACH.

Professor BIRMINGHAM gave a lantern demonstration of the form, position, and relations of the stomach as seen in bodies which have been hardened by intravascular injections of formalin. The chief points upon which he dwelt were:—That the empty stomach was contracted, not collapsed, its pyloric portion resembling thick-walled small intestine; its cardiac portion rounded, but attenuated; its surfaces looking, the one up, the other down, and its long axis nearly horizontal. In this condition it rests on the "stomach bed," occupying only the lower part of the "stomach chamber," the upper part of this space being occupied by the great omentum and the transverse colon, which double up over the empty stomach and lie between it and the diaphragm. The large, flattened, and collapsed stomach, with anterior and posterior walls in contact, usually described and pictured, is not found in the hardened body. Three stages are recognised in passing from the empty to the distended condition. In the first the fundus and cardiac portions were expanded, the pyloric portion remained contracted, and the lesser curve sharply bent as in the empty state; in this stage the stomach resembles a Florence flask, strongly bent at the junction of neck and body. In the second stage the cardiac portion is further expanded, and the pyloric portion opens out, but the junction between the two is distinctly marked. In the third stage there is an enlargement of all the axes of the organ; the distinction between pyloric and cardiac parts is almost lost; the pylorus is carried an inch or two to the left of the middle line, and the antrum pylori is developed. But in all these changes there is no rotation

around the long axis of the organ, with a raising up of the great curvature, &c., as commonly described. The distended stomach lies obliquely, its long axis running from the fundus, not vertically, as we have been taught in recent times, but inwards and downwards, at an angle of about 40-45 degrees with both the horizontal and mesial planes. The various views expressed by the author were illustrated by photographs of hardened bodies, and also by a series of hardened stomachs, showing the various stages of distension, and showing the sphincter action of the diaphragm on the lower end of the oesophagus.

Dr. PATTEN remarked that as one ascended the scale from the lower animals there was an increasing tendency for the long axis of the stomach to become somewhat oblique, while, at the same time, the transverse colon became more distinctly marked, and he suggested that the transverse colon was the principal factor in determining this change in the position of the stomach.

Mr. TAYLOR pointed out that the beginning of the small intestine occupied a deep recess in the left region of the abdomen below the stomach, from which it is separated by the transverse meso-colon, only, as just pointed out by Professor Birmingham. If the meso-colon be torn through, and this portion of the intestine connected to the under surface of the stomach, the result will be that the intestine will be connected to the lowest part of the stomach, and thus gravity will assist the passage of the food into the intestine.

Professor BIRMINGHAM, in reply, thought the obliquity in the human stomach was probably due to the wide thoracic framework. In a female subject with a very constricted waist, the stomach (which he exhibited) lay almost vertically on the left side of the vertebral column. Regarding the question of the existence of a valve at the cardiac orifice, he thought that little reliance could be placed on observations made on dried specimens. The return of food from the stomach into the oesophagus would be amply guarded against by the contraction of the muscular fibres of the oesophagus and the crura of the diaphragm, as illustrated by a specimen exhibited.

VISCERAL ANATOMY OF GIBBON.

Dr. CHARLES J. PATTEN brought forward a communication dealing with the visceral anatomy of the gibbon. The paper dealt principally with the form and position of the thoracic and abdominal organs. Many of these (lungs, heart, stomach, spleen) very closely resembled those of the human subject, as one might anticipate in such a highly developed anthropomorphous ape. The specimen was first hardened in formalin to ensure the contour of the viscera.

The Section then adjourned.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD THURSDAY, FEBRUARY 22TH, 1900.

Mr. W. T. THOMAS, F.R.C.S., Vice-President, in the Chair.

CASES.

MR. R. W. MURRAY showed a patient upon whom he had performed the operation of tarsectomy for double club foot.

Dr. ALEXANDER related two cases in which he had removed foreign bodies from viscera, and showed the specimens, (1) pieces of coal and pebbles removed from the vagina, (2) a piece of slate pencil removed from the male urethra.

RECENT OPERATIONS ON THE STOMACH.

Mr. RUSHTON PARKER read a paper on this subject comprising fifteen cases, of which eight occurred in the last six months, and twelve in the year. Four were "gastrostomies" in men, for carcinoma of the oesophagus, the operation being that known by the names of Hahn, Franck, and Albert. Two of the patients died within six months of acute phthisis, one in six days of bronchitis, one in three months, suddenly, of syncope. He considered the procedure in suitably selected cases of

value, but probably the least satisfactory of the temporary operations on the stomach. Four were "gastro-enterostomies," three in men and one in a woman. The symptoms all pointed to carcinoma, and although a tumour was felt only in two, in all a growth was found, which was either too firmly fixed or surrounded by secondary deposit to permit of removal. Two are still doing well, the others getting worse, in one the tumour is increasing, and is undoubtedly cancer, whilst in the others no microscopical verification has been made, and between carcinoma and gumma there is no means of being certain in the examination by eye and hand alone. The operations were well borne, and the healing rapid. No adventitious appliances were used. The nearest piece of jejunum was attached to the lower part of the stomach, an incision 3 ins. long being made in the axis of each viscus, and continuous silk sutures used, are set through mucous membrane, another through peritoneum. The operation quickly admits of satisfactory feeding, and although only required for temporary purposes, may now and then give permanent relief in the event of suspected carcinoma proving to be non-malignant. Two cases of excision were shown, one a woman, *æt.* 37, for malignant disease (ascertained microscopically) to the left of the pylorus, still in good health without any sign of recurrence after two years; one a man, *æt.* 49, for whom pylorotomy was done a year previously for a tumour thought to be malignant, but at the operation regarded as gummatous, and proved microscopically to be so. Three cases of pyloroplasty were discussed, two for contracted pylorus due to gastric ulcer, the other for ulceration (probably syphilitic) contracting the right half of the stomach.

Two patients were shown after perforation of gastric ulcer, one, a chronic perforation with limiting adhesions to the liver necessitating complete section of the stomach near the cardiac end before suture; the other a perforation operated upon within six hours of the accident. Hour-glass contraction of the stomach existed to the diameter of an inch, with the perforation in front of it. Free incision of the contraction right and left was made, the edges of the perforation cut away, and the wound in the stomach drawn together, end to end, and separated in the middle, as in pyloroplasty. Both patients are in good health.

Mr. F. T. PAUL agreed that Frank's modification of Hahn's operation of "gastrostomy" was the best, but unless a diverticulum of from 2 ins. to 2½ ins. in length could be withdrawn to form the fistulous passage in the abdominal wall; it was better to do Senn's operation, which he thought the more efficient, but not so easily recovered from as Frank's. He has ceased to use all mechanical appliances, except Murphy's button, and this he believes might generally be dispensed with.

In "gastro-enterostomy" he considered there was a danger of the intestinal juices escaping into the stomach, and of the anastomosis proving only temporary; the former trouble was more common in the posterior operation, and rarely met with when the opening was made in front. This operation cannot compare with either pylorotomy or pyloroplasty in the benefit afforded to the patient.

Pylorotomy was never likely to be a frequent method of operation in cancer of the pylorus, owing to the fact that by the time the diagnosis is made, the extent of the growth, fixation, &c., renders it unfeasible.

Pyloroplasty had given him the best results in practice. With reference to the suture of perforated gastric ulcer, he considered that drying out the peritoneal cavity was better than flushing, he always washed viscera that were withdrawn from the abdomen, but limited the internal flushing to localised septic tracts that were isolated by adhesions or otherwise.

Mr. ROBT. JONES referred to a patient with large nodular mass at the pylorus, so fixed that, after opening the abdomen, pylorotomy was considered undesirable. Now, three years later, the patient is nearly well, and the tumour has disappeared. This was of interest in view of reported cases of gastro-enterostomy for malignant disease, when years had passed and the patient lived. A microscopic examination was necessary before malignancy could be pronounced.

Mr. W. THRELWALL THOMAS drew attention to the un-

satisfactory state of our knowledge of the pathology of the stomach, two of the cases referred to in the paper being due to syphilis, a cause rarely mentioned. Familiarity with the details of visceral suture, obviated the use of mechanical appliances, such as tubes, palates, and buttons. It was necessary to deal boldly with the stomach in such cases as perforated gastric ulcer, cutting away the margins of the ulcer until normal stomach wall was reached, and continuous suture with silk was a great advantage. He advocated early operation in cases of gastric ulcer with perforation, and "mopping" in preference to washing out the abdomen. The early recognition of the time when medical means prove unavailing is necessary for an early resort to surgical means if considered advisable after consultation.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD IN THE MEDICAL INSTITUTION, LIVERPOOL, FEBRUARY 15TH, 1900.

The President, Dr. HELLIER, in the Chair.

Dr. BRIGGS, Liverpool, showed (1) a fibro-myoma, almost completely calcified, removed from a patient, *æt.* 60, by Baer's operation. The tumour weighed 5½ lbs. The patient made a good recovery. (2) Calcified fibro-myoma weighing 5½ lbs. enucleated from the parametric cellular tissue of a woman, *æt.* 52. The patient died on the eighth day from exhaustion. In both cases ascites was present.

Dr. LLOYD ROBERTS.—Calcified fibro-myoma, the size of a child's head, removed post-mortem from a woman, *æt.* 70.

Dr. T. GRIMSDALE, Liverpool.—Uterus with multiple fibro-myomata removed per vaginam by morcellation.

Dr. T. E. GEMMELL, Liverpool.—Fibro-myoma removed by enucleation from a uterus three months pregnant. The pregnancy was not interrupted.

Dr. BURTON, Liverpool.—Pedunculated fibro-myoma removed by abdominal section.

Dr. DONALD, Manchester, read notes of a case of RUPTURED EXTRA-UTERINE PREGNANCY, AND SHOWED THE SPECIMEN.

The patient, *æt.* 30, had been married 4½ years, and had no previous pregnancy. The menstrual periods were regular until October, 1899, but in that month the period was delayed four days. Uterine hæmorrhage then came on and lasted until the date of operation (16 weeks.) In December she had sickness and nausea and was seized with a pain in the right iliac region. Early in January the sickness was very severe. The abdomen was distended and tender, and an obscure swelling was felt bi-manually in the right iliac region. The diagnosis was tubal pregnancy with rupture into the right broad ligament. Palliative treatment was recommended as it seemed probable that the embryo had succumbed. The conditions improved somewhat—although the sickness was at times troublesome—until February 3rd, when she had severe abdominal pain and marked increase of sickness and exhaustion. On February 6th abdominal section was performed. The abdomen contained large blood clots and much fluid blood. A four months' fœtus and placenta were found lying loosely amidst coils of intestine. No sac and no amniotic fluid were seen. The pelvic organs were not felt, as they were completely shut off by adhesions. The abdomen was cleansed with gauze sponges, but no attempt was made to remove clots adherent to intestines. A large quantity of iodoform gauze was packed into the abdomen. Convalescence, after the first forty-eight hours, was uninterrupted. *Remarks.*—The case was probably one of secondary rupture into the abdomen. Neither the fœtus nor the placenta showed any signs of maceration or degeneration. From a clinical point of view it is interesting that the most prominent symptom throughout was the vomiting, and that even after the final rupture, pain and exhaustion and symptoms of peritonitis were more marked than the signs of hæmorrhage.

Dr. J. B. GRIMSDALE (Liverpool) related a case o

"Metrorrhagia" occurring in a single woman, æt. 31. The bleeding had been almost continuous for three years. She had been in bed for eighteen months, and various modes of treatment, including plugging and electrical treatment, had been tried without effect. Vaginal examination revealed no cause for the bleeding, the uterus being small and mobile. The uterus was explored and curetted, but three weeks later the bleeding again commenced with little diminution of the amount. The patient was extremely anæmic. Examination of the blood gave evidence of simple anæmia only. Abdominal section was performed, and the ovarian arteries were ligatured. The bleeding immediately ceased, and since then the patient has had a normal menstrual period lasting five days. Remarks were made by Dr. Briggs, Donald, and Professor Sinclair. Dr. Grimsdale replied.

Dr. MATHAN RAW, Liverpool, related two cases of "eclampsia" treated with success. In the second case the patient appeared to be moribund for some hours after delivery. Two pints of normal saline solution were transfused into a vein. This was followed by immediate improvement and life appeared to be undoubtedly saved by this measure.

Dr. RAW also showed a full-term fœtus removed by Cæsarean section after repeated attempts had been made to deliver by forceps. The child was dead but the scalp and vertex showed extensive subcutaneous hæmorrhage.

BRITISH ORTHOPÆDIC SOCIETY.

MEETING HELD SATURDAY, FEBRUARY 17TH, 1900.

MR. G. CHISHOLM WILLIAMS showed cases of (1) Ganglion of the Extensor Tendons of the Foot; of (2) Caries of Dorsal Vertebra; and (3) Severe Hallux Valgus with Hammer Toes.

Mr. JACKSON CLARKE, commenting on the first case, said that he thought partial excision of the sac the best treatment.

Mr. WILLIAM THOMAS said that he had never seen recurrence after subcutaneous free division of the sac and extrusion squeezing out of the contents.

Mr. ROBERT JONES said that simple ganglion got well after rupture, but pressure must be kept up for some time afterwards. In other cases he found that injection of a few drops of liquefied carbolic acid effected a cure.

Mr. NOBLE SMITH said that he preferred subcutaneous puncture and evacuation of the contents, followed by pressure. In the event of recurrence he used Tod's glycerine injection.

Mr. MUIRHEAD LITTLE said that he thought that the case shown was one of ganglion of the sheath of the tibialis anticus.

Mr. WILLIAMS, in reply, said that he had never found any difficulty in curing ganglia by rupture, provided that enough pressure was applied. In the case of hallux valgus he could trace no history of rheumatism. The patient has flat foot.

TUBERCULOSIS (?) OF SHOULDER.

Mr. MUIRHEAD LITTLE showed a boy of ten with a stiff shoulder, probably due to tuberculosis. There was a history of injury. When first seen nine months ago, the humerus was firmly fixed on the scapula, its head was slightly displaced upwards and inwards. There was no swelling and no sign of local inflammation. Under an anæsthetic the humerus could be easily moved on the scapula through 90 degs. of abduction. Rotation was very limited. There was a roughness in the movement of the joint. The other shoulder-joint allowed an unusual degree of mobility, so that the boy was able to turn his olecranon to the front. Both elbow-joints were normal except for slight hyper-extension.

Mr. ROBERT JONES thought the case was one of tuberculous disease with subluxation, and disadvised passive movement. The best plan was to keep the parts at rest until inflammation had subsided, and then to try to impart as much mobility to the scapula as possible. Happily the scapula was very accommodating, and such treatment gave better results than excision.

Mr. NOBLE SMITH recommended drilling into the head of the humerus. This often promoted absorption.

Mr. JACKSON CLARKE showed a skiagram of a somewhat similar case. In this ankylosis dated from nine months of age, and there were signs of local inflammation. He believed it was tuberculous, and not syphilitic.

Mr. WILLIAM THOMAS thought there was much subluxation in Mr. Little's case. He believed that excision would give the best result.

Mr. JOHN POLAND agreed that the case was tuberculous. Such cases were so rare that every example was interesting. His experience was that tuberculous of the shoulder differed considerably from that in other joints. Its progress was very insidious, the amount of deposit being at first small, and very slight injury would produce dislocation. He thought that nothing short of excision would produce a movable limb.

CASE OF HALLUX VARUS.

Mr. POLAND showed a skiagram of a case of hallux varus probably of paralytic origin. He had replaced the part after dividing the tendon of the abductor pollicis and the internal lateral ligament. He also showed casts of the hands of an infant with defect of the thumb on one hand and redundancy of digits on the other.

Mr. JACKSON CLARKE showed a skiagram of an old case of dislocation of the hip following coxitis, on which he had performed intertrochanteric osteotomy to correct adduction. The pelvis showed secondary changes on the affected side.

Mr. POLAND also showed a skiagram of a case of separation of the lower epiphysis of the radius. He pointed out that a radiograph would not show the separation unless there were displacement.

HALLUX VALGUS AND HALLUX VARUS.

Mr. JACKSON CLARKE, in opening the discussion upon hallux valgus and hallux varus, observed in regard to the former that in rheumatoid cases the head of the metatarsal bone presented a groove denuded of cartilage and corresponding to the inner edge of the base of the first phalanx. *Congenital cases of hallux valgus* were referred to. He considered that they were due to intra-uterine pressure. A variety of causes had been suggested as most commonly producing *acquired hallux valgus*; but he thought the more severe cases were due to the combined action of a predisposing and an exciting cause. The former was usually rheumatoid arthritis and the latter wrongly-shaped boots. The more commonly occurring *concomitant deformities* were hammer-toe, flat-foot of the ordinary and of the transverse type (the latter being sometimes complicated by metatarsalgia). The *treatment* consisted of active and passive exercises, instrumental and operative measures. When operation was called for excision of the whole of the head of the first metatarsal bone was to be preferred. *Hallux varus* was seen as part of congenital equino-varus, and as an acquired condition in severe genu valgum, some cases of paralysis, &c. Pronounced hallux varus was present in some cases of dichotomy of the great toe, and it might be caused by paralysis in some cases. *Results*.—Mr. Clarke expressed his belief that every case of hallux valgus was curable, the most troublesome cases being those in which a second hammer-toe had been (quite unnecessarily) removed previously to the patient being seen.

Mr. JOHN POLAND showed a skiagram of a remarkable congenital case, the second phalanx being completely displaced to the inner side of the first. He pointed out, as regards hallux valgus, that there was a class of cases of great interest in children from 14 to 15 years old who had not worn tight or narrow-toed boots.

Mr. ROBERT JONES preferred to treat the subject from a clinical rather than a pathological standpoint. He was in the habit of dividing or excising an inch of the tendon of the great toe. The best treatment in pronounced cases was excision of the head of the first metatarsal bone, failing which gradual mechanical correction might be resorted to. He had seen a boy, æt. 14, with well marked hallux valgus, yet this boy

had never worn boots or shoes. Osteotomy of the shaft of the first metatarsal bone was useless.

Mr. TUBBY agreed as to the osteo-arthritis nature of the deformity, but he would say that not merely 50 but 90 per cent. of the cases were due to rheumatoid arthritis, which he believed was a dyscrasia, which was apt to fall upon any joint which happened to be exposed to pressure or irritation. If enough bone was removed there was no need to divide the extensor proprius Pollicis.

Mr. MUIRHEAD LITTLE said the displacement of the sesamoid bones in hallux valgus showed plainly in skiagraphs in the first interosseous space, and had been removed by at least one surgeon as the probable cause of symptoms! Toe posts were useless.

Mr. KEETLEY thought that excision of the head of the metatarsal bones was the best. Wedge osteotomy was sometimes effective. He had never succeeded in curing a case by any mechanical appliance, though he had given many cases a very fair trial. He thought that there were two classes of cases: those associated with flat foot, and the great majority those caused by improper boots. He did not believe, apart from rickets, that hallux valgus affected people who had never worn boots.

Dr. BLAGE said that there were in his opinion three classes of cases. 1. Congenital. 2. Due to rheumatoid arthritis. 3. Due to tight boots. When he was a student he had seen operations of osteotomy, and the immediate results seemed excellent, but when he got into practice he found that the trouble recurred after osteotomy, and excision of the head of the bone had to be performed.

Mr. NOBLE SMITH said that in the slighter cases much might be done by persuading the patients to wear proper boots.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, March 4th, 1900.

ERECTILE TUMOURS.

M. LE DENTU read a paper at the meeting of the Académie de Médecine on the treatment of angiomas by the injection of coagulating liquids. The solution employed was that of Piazza, and the quantity injected varied from two to ten drops for the small tumours and from twenty to forty drops for the largest angioma at one sitting. The instrument used was the ordinary Pravaz syringe, and the liquid was introduced very slowly. Before operating, a ring of some material was placed around the tumour in order to prevent the blood from returning into the circulation, and also the escape of clots beyond the erectile zone. The ring was maintained *in situ* twenty minutes, so as to avoid the danger occurring from a possible embolus, for the coagulation in the vessels and the erectile caverns was far from being instantaneous. The decrease of the tumour frequently required several months to be complete. In the majority of cases one injection was sufficient to arrest the development of the tissue. At a distant date—three months, six months, or even a year—if the angioma had not disappeared, the injection might be renewed. The results obtained by this method of treatment were, the speaker said, encouraging. If electrolysis should be preferred for angioma of the face, it was none the less true that ignipuncture and coagulating injections offered important resources to country practitioners who did not possess an electric apparatus. M. Berger opined that extirpation was the best treatment of erectile tumours where they were not too extensive; where extirpation was not feasible preference should be given to ignipuncture or to the galvanic

cautery. Another member said that he obtained very good results with the thermo-cautery.

INFLUENZA.

Prof. Huchard read a paper in which he insisted on the benefit derived from administering to persons attacked with the grippe, and at the very outset, one large dose of hydrobromide of quinine, 20 to 25 grains, the doses of 10 grains habitually employed were entirely insufficient. A small quantity of ergot of rye (5 to 6 grs.), might be associated with the quinine. If the nervous depression were considerable, a fiftieth of a grain of strychnine might be ordered. In the majority of cases it would be well to facilitate the urinary secretion so frequently compromised, by prescribing milk régime.

Dr. Hayem considered that the massive doses recommended by the above speaker would provoke gastric disturbance, which would be far from improving the condition of the patient. He was not a partisan either of the milk diet, the customary food should be allowed.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, March 3rd, 1900.

ACROMEGALY AND MYXEDEMA.

In *Volkmann's Klin. Vwag.* is an article by F. Pineles on the relation of acromegaly to myxedema and other blood-gland diseases. To acromegaly, which is almost always found associated with a pathological change of a blood-gland (hypophysis) are often associated other morbid alterations of other blood glands i.e., glands with internal secretions. Above all, the genital glands almost always exhibit some disturbances of function which express themselves either in a primary genital atrophy or clinically in permanent amenorrhœa. Further, there are in most cases various changes in the thyroid, and clinically a combination of acromegaly and myxedema or Basedow's disease. In the same way the oft-recurring glycosuria and diabetes point to anatomical or functional disturbance of the pancreas. Also in myxedema and Basedow's disease a number of symptoms are observed which are connected with morbid changes of other blood glands than the thyroid. Typical pneumonia of Basedow have often preceded a myxedema. Both in acromegaly and myxedema complete abeyance of the sexual function is a frequent occurrence. There is a connection between Basedow's disease and amenorrhœa. It has been experimentally proved that atrophy of the genital organs follows extirpation of the thyroid in animals. From this it follows that acromegaly, myxedema, cretinism, Basedow's disease, and in many instances diabetes, also are diseases of blood glands, in the course of which anatomical or functional disturbances of other blood glands arise. There seems to be, therefore, an anatomical and physiological relationship between many blood glands which shows itself clinically in the fact that in disease of one blood gland symptoms crop up that point to disturbance of function of another blood gland. As regards the pathogenesis of acromegaly, the hypophytic disease is not to be classed as a symptom, but as a cause of the disease.

In the *Deutsch. Zeit. f. Chir.*, 53, 304, Dr. Carl Frantcha contributes a report on three cases of

ACUTE DISEASE OF THE PANCREAS.

In two of the cases, after a considerable period in which gastric pain had been present, symptoms of ileus suddenly came on. Laparotomy was performed. In the one case there was necrosis of fatty tissues; in the other nothing beyond a slight redness of the serous covering of the intestine. Death took place in both cases; and in both necrosis of the parenchyma of the pancreas with interstitial hæmorrhage was found.

In the other cases a cystic tumour had formed only a few weeks before below the left ribs, which might be a hydro or a pyonephrosis. The kidney was cut down upon and found to be healthy. The tumour lay in the *bursa omentalis*; the walls were torn in the attempt to remove it. It was therefore stitched to the wound. Death followed from peritonitis. At the autopsy the pancreas was found to be converted into a cheesy, opaque, white mass, and microscopically the tissues were found to be necrosed. The cyst wall was pure connective tissue. The author classifies the case a pseudo cyst, i.e., such as arise in inflammation of the pancreas. There were no pancreatic ferments in the slightly turbid fluid contained in it.

At the meeting of the Medical Society of the 14th ult. Hr. Virchow showed bony preparations from a case of

CYSTOCARCINOMA TOGETHER WITH CHALKY METASTASES IN THE INTERNAL ORGANS,

the lungs, stomach, and kidneys. During life there had been a hypnotic condition of the vertebral column. In the first sacral vertebra was a large cavity. The whole condition pointed at first to cystoid formations, until further examination into the not smooth but rough walled cavities showed a milky fluid such as is met with in medullary tumours, and which was plainly in some relationship to a flat carcinoma discovered in the stomach, and which looked very much like an ulcer. The rarely observed combination with chalky metastases in the case had been determined by Davidsohn, who had for a long time been working on the subject of such metastases.

At the Free Society of Surgeons Hr. Heinze showed a specimen of

SPONTANEOUS RUPTURE OF THE ŒSOPHAGUS.

The patient was admitted into the St. Hedwig Hospital in a very bad condition exhibiting the symptoms of perforating ulcer of the stomach. At the autopsy the stomach was found to be healthy, except for some catarrhal gastritis, but in the œsophagus 6 cm. above the cardiac orifice was a tear 3 cm. in length. There was nothing about the preparations that pointed to carcinoma, stenosis, or diverticulum, and microscopic examination only revealed a round-celled infiltration at the margin of the rent, simple signs of recent inflammation. There was no emphysema of the skin, as was generally met with in such cases.

Hr. Heintz then related a case of

RUPTURE OF THE URETHRA WITH PRIMARY SUTURE.

A man, whilst unloading boards, fell astride on the edge of one. He fainted for a few minutes, and when he came to himself complained of acute pain in the perineum. He was taken to the hospital, and there was extensive extravasation of blood in the perineum, the scrotum was discoloured, and the discolouration extended to the inguinal region. No urine could be passed.

The urethra was laid open and found to be completely torn across. The peripheral end was easily found, the proximal only after some searching. The two ends lay about 5 cm. apart. The rent was at the junction of the bulbous and cavernous parts. The speaker succeeded in bringing the margin together by interrupted sutures over which the bulbo-cavernous muscle was sutured. The wound was then packed. At first a few drops of urine came through the wound, but in a few weeks healing took place without a fistula remaining. Some weeks later the patient reappeared with symptoms of commencing stricture, but at the time of reporting a No. 20 Charrière bougie could be passed without any difficulty. The suturing in stages had been a manifest success; it had shortened the process of healing, and had allowed a large lumen for the urethra.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, March 3rd, 1900.

CONGENITAL HYPERTROPHY OF PYLORUS.

At the "Gesellschaft der Aerzte," Huny presented a boy, æt. 11, to the Society who had suffered from infancy from general alimentary disorder, whose principal symptoms were, swelling of the abdomen, especially in the left lower region, vomiting large quantities of half-digested food, false appetite, constipation, &c.

The objective symptoms noticeable were splashing or gurgling in the swollen region, cyanosis and undoubted emaciation. By blowing up the stomach with carbonic acid gas to determine its limits it was found to be enormously enlarged, extending downwards to the symphysis pubis.

In December, 1899, laparotomy was resolved on to discover the real cause, when a concentric thickened ring of hypertrophy around the pylorus, was found about a finger's breadth in width, without any cicatrix or other adhesions that would raise any suspicion of preceding inflammation. The wall of the stomach itself was greatly hypertrophied, being about a finger's breadth thick. Gastro-enterostomy was performed with a Murphy's button, after which the whole symptoms disappeared. The liver before the operation could not be percussed, but on operating was found lying across the median line and enlarged, but resumed its normal size and position after operation. The Murphy button is still *in situ*, as shown by the Röntgen rays, probably due to the enormously thickened wall of the stomach.

This he thought was doubtless a muscular congenital hypertrophy of the pylorus, which he thought was consistent with Tandler's case last week, which was a duodenal atresia of a congenital origin.

Of the literature on this subject, only four are on record; three of these were in the first year of life, and one boy in the sixth year. Two of the operations ended fatally.

SEROUS IRIDO-CYCLITIS.

Paltauf next showed photographs of a patient, æt. 22, who consulted him in 1898 for serous irido-cyclitis without any appreciable cause.

In the following year a number of small tumours appeared as unaccountably under the skin, which were quite movable along the neck, sterno-cleido-mastoideus

and back; along both forearms to the shoulders, and on the calves of the legs. The individual gland groups, such as the axilla, occipital and inguinal, were not markedly enlarged to assist in the diagnosis. Concurrent with these small tumours under the skin a dull precipitate occurred on the posterior surface of the cornea. The microscopic examination of one of these small tumours which was excised showed that it was situated in the upper part of the sheath of the muscle and could be passively moved from one place to another. It was composed of granulation tissue with epithelial cells among which coursed fine vessels and leucocytes. From these data one could instantly conclude that the tumour was not a neoplasm, and must therefore be an inflammatory product—tuberculosis, actinomycosis, or some other morbid condition. Against tuberculosis the vascularisation of the mass was decided, as tubercle tends to assume a retrograde metamorphosis, while no infectious agent could be found to confirm actinomycosis, either by microscope, cultures, or animal injections, though several of the latter were performed, but all healed perfectly without any trace of infiltration or general disturbance. Internal changes were dulness in lower part of right lung, cough, but nothing to be found in sputa, while the spleen was greatly enlarged.

Other more unusual diseases such as multiple enlargements, cysticercus, and foreign bodies which the microscope could not discover. *Saccharomycetes* has usually a discharge which the present case did not exhibit. The diagnosis may, therefore, be said to be shrouded in darkness.

Bergmeister said that he had seen the patient with the morbid process in the iris. In the case of miliary tuberculosis the size of the tubercles was small in the iris between which small vessels were usually found, giving the tubercle a greyish color and sometimes a scarlet red. In many cases where the vessels become absorbed and the tubercle disappears, iridectomy may be required for *seclusio pupillæ*. Vision is usually impaired in both eyes.

Konigstein said he saw the patient a year ago, when he suffered from irido-cyclitis serosa, but was unable to give the etiology of the disease.

Paltauf said the blood had been examined and found normal. The presence of any parasite was excluded by the discovery of granulation tissue.

Fuchs said he had a female patient a short time ago with a similar histological tumour on the eyelid, which he removed without any subsequent infiltration or bad result. There was no appearance of other tumours on the body. Paltauf said that a similar case was recorded by Riehl, where the tumour occurred in the cartilage of the ear, which was under observation for thirty years. It was originally caused by a foreign body.

The Operating Theatres.

GREAT NORTHERN CENTRAL HOSPITAL.

TWO CASES OF LAPAROTOMY.—MR. PEYTON BEALE operated on a boy, æt. 10, who had been admitted a few hours previously suffering from an indurated mass in the right iliac region, acute pain in the left iliac region, constipation of fifty days' duration, vomiting, temp. 103, and furred tongue. The history of the case was as follows:—

The boy had been suddenly seized with severe pain in the left side of the abdomen, which came on immediately after dinner one week previously; he vomited and had a rigor. He was kept quiet, and purgatives were administered. His bowels acted well next day, but a hard swelling appeared in the region of the cæcum, the bowels could not then be made to act, although enemata were given frequently. Upon admission there was found to be a soft spot in the centre of the indurated mass, and the case was diagnosed as one of acute suppurative appendicitis. The patient being anæsthetised and the skin of the abdomen prepared, an incision of about 3 inches was made, its centre being the soft spot above indicated. A large irregular cavity was opened, and about four ounces of very foul pus were evacuated. In this cavity there was found—lying quite loose—the tip of the vermiform appendix. The cavity was washed out with 1:60 carbolic lotion, and a gauze plug inserted, the skin wound was reduced to about 1½ ins. in length by the introduction of two stitches, and the wound was dressed as usual.

The same surgeon operated upon a woman, æt. 34, who had been admitted with the following history—three days previously she had a severe attack of griping pain in the abdomen after over-reaching while attempting to get something off a high shelf. She had some nausea, and, feeling very ill, went to bed. The pain got worse, and vomiting commenced, and became fecal in three days. She had also absolute constipation in spite of frequent enemata. Upon admission she looked very ill, was vomiting freely, the vomited matter being brown and fecal, the abdomen was much distended, and it was impossible to feel anything through its walls. The patient stated that about two years previously she had been an in-patient at another hospital and suffered from "peritonitis." The case was thought to be one of obstruction by a band. Laparotomy was immediately performed, and although the whole of the small and large intestines were carefully examined, nothing abnormal could be found except two thin adhesions about 2 inches in length, passing between the parietal peritoneum of the anterior abdominal wall and the mesentery. There was no indication of any part of the intestine having been "nipped" by either of these bands or by anything else. The small intestine was punctured by a trocar and cannula, and the gas allowed to escape freely outside the wound. A fine silk suture was then inserted so as to close the aperture made by the trocar, the abdomen was filled with hot saline solution, and the wound closed and dressed in the usual manner.

Remarks.—MR. BEALE said, as regards the first case, the surgeon was lucky if he could get at these cases before general septic absorption had occurred, but whenever such a case presented itself, the soft spot—or it might be a small oedematous area as large as a sixpence only—should be sought for, preferably under an anæsthetic. He stated that in every case in which he had found this small soft or oedematous area, he had at once made an incision into it, and had always found the appendix, the tip generally, immediately beneath, and generally more or less gangrenous.

He said that the most important point to be remembered in appendix cases of this class was, "do as little as possible." Let out the pus and explore the cavity gently with the finger, but on no account enlarge the incision or scrape violently at the walls of the cavity.

By so doing, one ran the greatest risk of infecting the general peritoneal cavity; it was, moreover, of no use to try and ligature the stump of the appendix, for it would be found nearly always to be in a rotten state. He said also that in the majority of these cases the pain was anywhere but over the disease.

As regards the second case, he said the symptoms were remarkably severe, and he believed they were caused simply by an unusual strain put upon one or both of the small bands which were found. He had operated upon several cases of the same kind previously where in some instances nothing was found as a cause for the severe symptoms, but all had recovered completely, and the operation had removed all the symptoms at once. He stated that simple stretching of peritoneum might cause all the symptoms of complete obstruction, and especially in the case of the visceral peritoneum. He mentioned a somewhat similar case on which he had recently operated in King's College Hospital. Here the patient, a boy, was too ill upon admission to give any history at all, but he presented two abdominal sores where laparotomy had been previously performed. It was assumed that these had been done for tuberculous peritonitis, as he has had also some tuberculous glands in the neck, but on this occasion nothing abnormal was found with the exception of numerous adhesions between the mesentery and the under surface of the old scars. One peculiar feature of the case was the presence of gas, free in the peritoneal cavity. This boy made an uninterrupted recovery, and the operation relieved all his symptoms.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, MARCH 7, 1900.

THE GENERAL MEDICAL COUNCIL IN ACTION.

FROM time to time the august body which rules the destinies of the medical profession shakes off the bonds of its lethargic disposition so far as to prosecute some offender against the Medical Acts. Such

an event took place last week, when a decision of the first importance to the medical practitioners of the United Kingdom was delivered in a London Police Court. As almost invariably happens, the Council prosecution was that of a man whose name had formerly been on the Medical Register. At one time the defendant, E. W. Alabone, was a member of the Royal College of Surgeons of England, but in 1886 the College removed his name from its list for disgraceful conduct. The specific offence for which erasure took place was the appearance in *Moonshine* of an article laudatory of a special cure for consumption. Since the time of his removal from the Register he had, in accordance with the time-honoured observances of his fraternity, continued to practise medicine in a free and open manner. The only difference was that he described himself as "Edwin Alabone, M.D. Bellevue College, M.D. Phil., U.S.A.; D.S.C., F.R.M.S., ex-M.R.C.S. Eng." For using those descriptions he was now prosecuted by the Council, on the ground that the Act was intended to enable the public to distinguish between qualified and unqualified men, and that defendant was likely to deceive the public into the belief that he was registered under the Medical Act. The weakness of such a count must be at once evident to the veriest tyro in such matters, and to set the ponderous machinery of the law in motion upon an issue of that kind was a work of sheer and simple supererogation. With little hesitation the magistrate, Mr. Paul Taylor, placed the Council out of court. Defendant, he said, gave clearly the origin of his degrees, and expressly stated that he was an ex-member of the College of Surgeons. That being so, he found that Alabone described himself accurately as that which he was, without any intention whatever of misleading the public. The summons was accordingly dismissed, with ten guineas costs against the Council, and as the decision was based upon matters of fact and not of law, the magistrate refused to state a case for the superior Court. The actual cost of this ill-advised prosecution, needless to say, far exceeds the sum in which the Council was mulcted, and the loss is ultimately recouped from money paid by registered members of the medical profession. The money will not have been ill spent, however, if it call attention to the anomalies of medical legislation, and to the feebleness of the General Medical Council. What body with any common-sense business views would have undertaken a costly prosecution of a man for the publication of statements that are obviously and admittedly true? What must we think of the legal advisers of the General Medical Council for permitting so futile a step to have been taken, unless, indeed, the matter lends itself to the subtle vagaries of intellectual treatment which lead to lawsuits as certainly as a fierce conflagration ends in ashes? Why should the counsel for the prosecution have pointed out that defendant by using the titles complained of was likely to make the public believe he was registered under the Medical Acts? There are many legally qualified men in this country who are not registered. Will the Council prosecute

any of them for deceiving the public in a similar way into the belief that they are registered? Perhaps the Council and its legal advisers would kindly point out how the case of Alabone differs from that of the non-registered holder of a British qualification practising somewhere within the confines of the United Kingdom. Both publish and assume titles that are registrable in this country, but are not so registered. The fact of the matter is that registration should be compulsory upon all legally qualified practitioners of medicine. After the ridiculous fiasco of the Alabone prosecution even the General Medical Council may begin to perceive that the present voluntary system has its defects. Any other governing body would long ago have agitated for increased powers from the legislature to restrain from practice men whose names have been erased from the Medical Register. Not so the Council, which has simply ignored the open flouts and defiance of men who have proclaimed to the world by the medium of brazen plates that they have fallen from their former estate of legal qualification. It is often asserted that the Council has the ear of Government, and there can be no doubt whatever that its influence in that direction is great. Why, then, have we had none of the reforms that are so urgently needed in the medical world? Even now there is time for the Council to conciliate the main mass of the profession by increasing the number of direct representatives, and by taking vigorous steps to make registration compulsory, to prevent disrobed practitioners from further practice, and to obtain stringent laws against unqualified practitioners. The present constitution of the Council, however, hardly encourages any hope of progress in the foregoing directions. They are drawn mainly from the members of the consultant and teaching classes, to whom unfair professional competition means nothing, and the preservation of class privilege everything. The only way of solving that difficulty appears to consist in choosing the representatives of qualifying bodies on a broad electoral basis instead of allowing them to be nominated by autocratic and irresponsible intramural councils. Before finally leaving the case of the Alabone prosecution it may be well to ask how an unqualified man has managed about his death certificates for so many years. The recent action of the Registrar-General on this point opens up a prospect of an indirect attack upon a disrobed practitioner. We commend this point to the Medical Defence Union, a body which tempers legal subtlety with sound common-sense, and we venture to suggest that possibly with the aid of the local registrar, and a little timely pressure from Somerset House, the Union may sometimes succeed in bringing offenders to book, or, at any rate, in considerably restricting their field of action.

THE WAR AS A CAUSE OF INSANITY.

DR. CLOUSTON has just read his annual report to the managers of the Edinburgh Royal Asylum and

the public who are interested in such matters, and has taken occasion as usual to make some very striking remarks—one might almost call them sensational. If any man has made the subject of lunacy, its manifestations and its causes, attractive and interesting to the general public it is Dr. Clouston. Perhaps in writing for the general public as he undoubtedly does to a large extent, there is danger of departing from the scientific in order to satisfy the popular appetite and popular digestion, with what may be regarded as popular science. Thus, while touching on several points of interest, Dr. Clouston is not forgetful of the times, the sensations of the moment, and the great crisis through which we are passing, and he strikes a note which arrests attention when he speaks of the war and its influence in the production of insanity. In this connection he makes some very remarkable statements. 1. The statement that influenza is more productive of insanity than the war. If he said that influenza was productive of insanity without any comparison of other causes we should agree with him, but when he says that the war has produced no insanity, and therefore that influenza has more effect in the production of mental disease, we think that he is just travelling too fast. Putting influenza aside altogether, we should ask what is the value in Dr. Clouston's mind of the so-called moral causes of insanity, and if he admits that those so-called moral causes are a feature which has to be reckoned with, can he deny that the war, with all its attending anxieties, its suspense and despair, its multitude of bereavements, and consequent poverty and sickness, contributes to the moral equation and the immense mental result that must be recognised by and by? We have said that Dr. Clouston is travelling too fast, and what we mean is this, that the war is not yet over. We cannot even count the material and financial cost of it. It has not been of long duration, but will Dr. Clouston dispute the fact, that long after the war is over, its effects on moral and social character will still be felt, and will still produce a depressing effect on many nervous systems. If we consider for a moment the anxiety, strain, uplifting and down setting of our emotions, the distraction from business, the inhibition of that energy which should be expended in the ordinary channels of daily life, and this in people who have no relatives at the seat of war. How much should this be multiplied if applied to relatives of soldiers "at the front?" We take it then that Dr. Clouston has not regarded this subject with that far-seeing scientific acuteness and wisdom which we should have expected of him. 2. Perhaps, less hasty is his generalisation from the fact of the war having not yet produced much, if any, insanity, that this is evidence of the selfish and unaltruistic character of the present day. Here, Dr. Clouston is speaking from observations which are the result of evidence culled from his large experience of human nature, and we are not prepared to dispute this, but there is no more selfish character than love of offspring, and this will

show itself intensified through suffering during the present war, and a morbid factor which will yet tell its own tale. Although we have sometimes to disagree with Dr. Clouston, we have also to acknowledge how quick he is to seize on the circumstances of the moment, and the events of public interest, and to throw light on them from a psychological point of view. We have no doubt that when his report appears it will be read with interest, all the more because of the controversial questions which it has raised.

THE PATHOLOGY AND TREATMENT OF APPENDICITIS.

ALTHOUGH the subject of the pathology and treatment of appendicitis has been under discussion for many years past we are still far from a complete knowledge of this curious lesion. It is now recognised on all hands that appendicitis is always of infective origin, and this observation applies as well to a mild form, such as mere appendicular colic, as to the graver forms associated with perforation, gangrene, and peritonitis. This is a very important point, because it establishes once and for all the pathological identity of all forms of the disease, and it explains why it is impossible to forecast in a given case the ultimate result. As was clearly pointed out in the course of the discussion on the subject which took place last week at the Medical Society of London, the so-called catarrhal appendicitis of to-day may be the fulminating appendicitis of to-morrow, in fact, as physicians know but too well, the difficulty of distinguishing *ab initio* between mild and serious cases is more or less insurmountable. Physicians and surgeons still differ greatly in opinion as to the necessity for operation, and as to the precise moment at which such operation is best undertaken, but order is gradually being evolved out of chaos, and this difference of opinion now only obtains in regard to first attacks. There is a general consensus of opinion as to the desirability of operating in the chronic recurrent cases, and in the cases with severe initial onset. Although no hard and fast rule can be laid down for the guidance of physicians in determining the necessity for surgical intervention it is beginning to be recognised that grave responsibility is incurred by the practitioner, called to a case in the early stage, that is to say, at a stage when it is impossible to draw a sound conclusion as to its probable course, who refuses to advise operation. Great stress was laid on rapidity of the pulse as an indication for surgical intervention and this symptom is unquestionably far more significant than the temperature. Another interesting point is that the absence of swelling or tumour over the region of the appendix is not *per se* a contra-indication for operation; indeed, such cases not unfrequently prove to be of the graver kind. The presence or absence of this sign depends upon the anatomical position of the appendix, and this, as is well known, varies very greatly. A sudden onset, with a rapid pulse and tenderness over the appendix, with or without the formation of a tumour, suggests the

desirability of operation. A more gradual onset, with a steady pulse and early formation of a tumour, justifies delay, though this must be qualified by the absolute necessity of watching the patient closely taking the pulse rate every hour or two, the better to appreciate any sudden change in the condition. Surgeons in general are agreed in discountenancing the administration of opium and no doubt its routine employment in large doses serves only to mask the symptoms and to induce a sense of security not justified by the condition of the patient. Nevertheless, this drug is capable of rendering great service if administered with one or two provisos. First of all no opium should be given until the practitioner has made up his mind as to the sort of case he is dealing with, especially in view of the necessity for operation. Even then it should not be given continuously or in doses which would determine a condition of narcosis. Subject to these conditions opium calms the restless irritability of the patient, and while contributing to the relief of his suffering it does not hinder diagnosis nor prejudice an operation should this subsequently be decided upon. The fact that a very large proportion of the cases which are described as ending in recovery, relapse after a variable interval and are ultimately operated upon, renders it incumbent upon us to accept the term "recovery" with some reserve. One precaution imposes itself, viz., that a patient whose symptoms, after a first or second attack, have subsided, ought to be kept under observation in order to determine by periodical inspection whether the lesion has completely cleared up. In many cases it will be found that some induration or tenderness over the region of the appendix persists even after apparent recovery, and such a patient must be regarded as the possessor of an explosive focus which may at any moment place his life in jeopardy. The statistics of the so-called recoveries are still incomplete, but if it can be shown that sooner or later the majority recur a strong case will have been made out for operative treatment as a routine measure in dealing with this affection.

Notes on Current Topics.

The Dublin Sanitary Inquiry.

THE Commission appointed by the Lord Lieutenant has been sitting for the past three weeks from day to day, but, in our opinion, the result, so far, is not altogether satisfactory. A number of Medical Officers of Health and other experts from the greater English and Scotch towns have told the Commission, with much self-gratulation, what has been done by them, and what, they think, ought to be done. The authorities have only to cram sanitation down the throat of the poor population of the city, and to extract the million of money which the process will cost from the pockets of the Dublin ratepayers, and all will be well. Dublin is grateful for the instruction, but feels compelled to decline it with thanks. The sanitation politics and

financial policy of wealthy English towns, dealing with a more or less cleanly and law-abiding poor population, does not touch the necessities of Dublin at any point, and the information afforded by these experts though interesting to the sanitarian, is of little practical use. The lowest class population of the city, whose chronic squalor, half starvation, and intemperance are the chief factors in the excessive mortality in Dublin, may be encouraged, educated, and persuaded, with a little firm pressure, to live more clearly and soberly, and the tenement farmers who draw their incomes from such people may be forced to reform the home conditions, but we are convinced that the present chance of radical improvement in Dublin would be lost if the inevitable panacea of these ultra sanitarians (*i.e.*, the policeman) is too much in evidence. Furthermore it is simple waste of speech for these sanitarians to tell the Dublin Corporation that no reform of sanitation can be effected without the outlay of half a million of money on palatial isolation hospitals and Rowton Houses. If such establishments are to be provided Dublin must be content to begin on the most moderate scale, and to look for the beneficial result years hence. Then, again, the Commission has, so far, been swamped by the evidence of amateurs and other sanitarians who volunteered their testimony, which has been useful because it has indicated unanimity as to the causes of Dublin insalubrity, but has, otherwise, thrown little light on the subject. The witnesses have sworn that slaughter-houses should not be located at the back door of a tenement house; that the emanations from the manure of reeking dairy yards ought not to enter our households through our drawing-room windows; that the refuse of ashpits should not be carted through the city at midday; that a sufficient organisation should be maintained to compel the owners and occupants of tenement dwellings to make at least a pretence of cleanliness, that infected patients should be provided with some accommodation which would prevent them developing the disease in the family circle or wandering about the city with it on them, and that the very poor should be given the chance of living decently in decent dwellings if they wish. The citizens of Dublin did not need a Lord Lieutenant's Commission come from the Castle to tell us all this, as every educated individual in Dublin has, for long years, known it well; but now that it has again been emphasised, the Commission may, we suggest, proceed with advantage to deal with these conditions in a practical way and in a way appropriate to the conditions of Dublin, and not to those of Manchester or Glasgow. It is for them to indicate what changes in the municipal or public law of the city are necessary to carry into effect a root and branch reform in the sanitary arrangements—to consider how the money needed is to be found in the most economical amount and easiest way—to devise methods by which the poor of the city may be wheedled into accepting improvement, and, above all

things, to take steps which may prevent the shelving of all propositions for change in the interests of the butchers, the dairymen, and the tenement farmers, and the publicans. To do this and, eventually, to educate the poor of the city into cleanliness and self-respect is "work for the Gods," and, if the Commission can only start that work it will have well justified its existence.

Failure of the Inebriates' Act.

It is a matter of regret that the special Act dealing with inebriates, from which so much was hoped, has hitherto failed in its purpose. The reason is that there are no homes to which habitual drunkards can be sent, so that the Act remains a dead letter for a good and substantial reason. Last week the drawbacks of this very undesirable state of matters were illustrated in a London Police Court, where a woman, a chronic inebriate, had been remanded several times in order to that a home might be found for her under the Inebriates' Act. The court missionary, who had endeavoured to find a home for the prisoner, reported the following communication from the Government Inspector under the Act. "Dear Mr. X—, I am afraid I cannot help you. Duxhurst is, I believe, full: Ashford, being Roman Catholic, is out of it; and Bristol won't take London cases into either of their reformatories. The London County Council's own place will not be ready till April." The deadlock thus disclosed was completed by the statement of the magistrate that, excluding Roman Catholics, there were only fifteen women in homes. The question naturally arises as to whose duty it is to provide the homes necessary under the Act. As matters stand there is an obvious opening for private enterprise in that direction, although for various reasons public institutions would be preferable. It is hardly to be hoped that the present Government will take the affair in hand, so that for the present temperance reformers will have to remain content with the potential benefits obtained in the Act. By the way, it will be interesting to ascertain what is the salary paid to Her Majesty's Inspector under the Inebriates' Act, for according to his own showing the post he holds must be a sinecure.

Vegetarianism v. Tubercle.

THE vegetarians are always ready to combat fiercely any fresh point that may tell against their particular views, a zeal that does them no discredit. They are now up in arms over the recent observation of Sir J. Crichton Browne to the fact that tubercle is common in herbivorous animals, such as cows, but is practically absent in carnivora. At the same time he laid great stress on the importance of discarding every part of an animal containing the specific bacilli. A correspondent of a Midland journal maintains that this advice involves an inconsistency "for the carnivore devouring the whole carcass goes free of consumption, yet man using flesh in his dietary (although selected after inspection), contracts it to such an extent that 40,000 of our population die from it every year." A little

further consideration is needed for these criticisms themselves. First of all tubercle is a disease of domesticated animals, but is extremely rare, or altogether unknown among wild animals being in a state of nature. It is only when cows and other animals are herded together under unhealthy conditions that they become infected with tubercle. Hence the carnivora that live on wild animals eat flesh that is not specifically infected with tubercle, and the reason of their immunity is clear. As to the latter part of the argument, it must be conceded that tubercle is undoubtedly spread by eating the flesh of tuberculous animals. That is a good reason for exterminating infected beasts, and for insisting on proper sanitary surroundings for our flocks and herds, but is it a sound argument against flesh-eating? The use of rye bread produces a certain amount of gangrene, but are we on that account to forbid mankind from eating any more bread made from that widely-distributed cereal? Further, bread generally, which is often made under most filthy conditions, is possibly the source of much disease; at any rate, the statement that baking does not sterilise bread, advanced some years since at the Bristol meeting of the British Medical Association, has not been hitherto contravened. Lastly, the writer in the *Birmingham Daily Post* appears to think that the inspection of meat in this country is trustworthy. Perhaps it may interest him to learn that in the opinion of most sanitary experts, where any system exists at all it is so perfunctory, inadequate, and empirical as to be a standing reproach to the public sanitary administration of the United Kingdom.

Influenza Scotched, Not Killed.

WHAT with wars and rumours of wars, the national attention is for the time being diverted from home matters. In this way the fact that influenza is still playing havoc in our midst appears to have well-nigh slipped out of the minds of those who are not in the grip of that remorseless malady. Yet the returns of the Registrar-General write high upon the wall a record that may well give pause to the careless optimism of the man in the street, of whom it was long ago pertinently remarked that "familiarity breeds contempt." In the last available return from Somerset House the deaths attributed directly to influenza in London numbered 52, as against 109, 63 and 74 in the three preceding weeks. It was also given as a contributory cause of six other deaths, compared with three previous returns of 15, 11, and 15 under that heading. To these figures must of course be added a certain proportion of deaths returned under respiratory diseases, but which should properly be referred to influenza. Some of our winter seaside resorts are full of the disease, to say nothing of many inland towns. The moral of it all is that anyone who thinks he has a severe cold should be careful to ascertain whether he is not really suffering from influenza. The treatment of the two conditions differs widely, and the mildest case of influenza demands the most skilled medical attention available. Before long it is to be hoped that our sanitarians will find out the

way in which the germs of this disastrous disease are spread far and wide over the face of whole continents.

Infectious Diseases Hospitals.

THE Belfast Corporation is engaged in administering to the Dublin Corporation just now a useful lesson how not to settle the vexed question of a hospital for infectious diseases. Belfast has selected a site which is distant between five or six miles from the opposite side of the city, and it proposes to outlay £45,000 in buildings to provide 150 beds at £300 a bed, and to add £2,000 for sinking fund, and £6,000 for maintenance, yearly, to the taxpayers' burthen. As it is declared that the building must be "something of which the city may be proud," we may reasonably assume that architects and builders will satisfy the Corporation by erecting elaborate Queen Anne mansions, which will run the ultimately outlay up to £10,000 or £12,000 a year. We trust that the Dublin Corporation will not postpone indefinitely the realisation of a scheme for isolation hospitals by following the example of Belfast. The Dublin citizens want a building which shall be available for the accommodation of the infected poor when epidemics occur, but they do not want it placed five miles from the city nor decorated to suit the æstheticism of architects. If such provision cannot be made on other terms Dublin will have to do without it.

Personation of Qualified Practitioners.

It may be in the memory of our readers that an unqualified person named Holland was last year detected in practising under the name of a registered practitioner named Nugent, who had emigrated and died, and whose diploma Holland rented from the widow at 3s. 6d. per week. This ingenious person had actually succeeded in inducing the Council to reinstate the name of Nugent on the *Register* after it had been expunged by the Council itself, and he was enabled to do this by means of a false affidavit sworn by his qualified assistant, to the effect that he (Holland) was Nugent, and no one else, for which offence the qualified assistant was also struck off the rolls. We note a somewhat similar case which came before a London Police Court last week, in which one Collins was prosecuted for practising in the name of "Dr. Washington Evans," of London, who had been dead since November last. When a detective for the General Medical Council addressed a letter to Evans asking advice, he was answered by the defendant in Evans's name, and it was confessed by him afterwards that the fraud was carried on for the benefit of the widow. Collins was fined £2 and £5 5s. costs.

A MOVEMENT for the establishment of a University in Hamburgh has been set on foot and seems likely to be realised. There are in the city a considerable number of scientific institutions which are under central control, and have been working in harmony for many years, and it only remains to combine them in the proposed University.

Her Majesty's Devotion to Her Wounded Soldiers.

WHEN the history of the present war in South Africa comes to be written, it may safely be asserted that one among its chief incidents to which special attention will be drawn will be the kindly, sympathetic, womanly interest which Her Majesty the Queen evinced in her wounded soldiers. Painful as it must be to our revered Sovereign at the evening of her life to learn of the sacrifice of life and the sufferings among the British troops at the seat of war, it is nevertheless plain that she has determined to do her share in testifying to the national appreciation felt for the gallant work of the Empire's sons. Could any spectacle be more fully illustrative of the Queen's devotion in this regard than that which occurred at Netley last week? The newspaper press reported that Her Majesty paid a visit to that institution, which lasted for three hours, and during that time took the opportunity of speaking a few kind words to every wounded soldier who had been admitted for treatment from South Africa. It must be conceded that such a kindly act as this, apart from the instinct which prompted it, was a feat of endurance of which the nation may be doubly proud, when it is recollected that it was performed by the Queen in her eighty-second year. It is largely by such acts as these that the Sovereign has from the commencement of her glorious reign bound up her life with that of her loyal subjects, and it is also such acts as these that the nation never forgets.

The Clinical Significance of Decubitus.

IN the observation of a patient suffering from some serious illness, the careful clinician cannot overlook the posture which the sufferer assumes. That is to say any diseases associated with the assumption of an almost characteristic posture by the patient, and in not a few instances this is helpful when the question of diagnosis is raised. Nevertheless it is remarkable how much variety exists in this regard, and how little has been the attention drawn to the subject. In an article by Dr. Affleck in the current number of the *Scottish Medical and Surgical Journal*, this subject is discussed from the point of view respectively of diseases of the respiratory system, diseases of the circulatory system, and diseases of the alimentary system, giving examples of decubitus in each. The paper is of special value inasmuch as it mainly deals with details which are not mentioned in text-books, and travels over ground which is seldom included even in clinical teaching.

Comforts for the Royal Army Medical Corps.

CONSIDERING the prominence which has been given to the gallant and devoted services rendered by the Royal Army Medical Corps in the South African campaign, it is somewhat surprising that it is not until the last few days that a movement has been set on foot to enable them to share in the distribution of "comforts" which a generous and patriotic public have freely contributed for officers and soldiers. No

doubt army surgeons do not stand in need of woollen socks and comforters, but their men are exposed to vicissitudes of climate and to the hardships inseparable from a campaign like the present fully as much as their combatant brethren; indeed, their work continues long after the ordinary soldier has put the rifle aside in favour of the toothpick or the night cap. We trust that the movement inaugurated at the Birmingham Medical Institute last week will meet with a generous response at the hands of the public, if only to encourage a very meritorious body of men to continue to discharge their onerous duties with a zeal equal to that displayed in the near past.

Swiss Medical Education and Degrees.

OUR readers are no doubt aware that Zurich and Berne Universities were the first in Europe to grant medical degrees to women, which they did about twenty years ago. These qualifications looked well on paper, and, as may be supposed, were not difficult to obtain in respect of either curriculum or examination, but, as far as Britain is concerned, they carried no professional privileges or prestige, although certain Colleges of Physicians accepted them as *ad eundem* for their final examination. It seems, however, that the very small expense of the Berne education has been too much for the unsophisticated Swiss, and to relieve them of this hindrance an old lady named Lenz has bequeathed the whole of her very handsome estate, near Berne, for the purpose of providing impecunious female students with the requisite education.

A Medical Slander Case.

A CASE of a kind which one cannot but regret to see in Court was tried last week at the Liverpool Assizes, in which Dr. Harris Philpots, of Orton, claimed damages from Dr. A. E. Davies, of Liverpool, for slander. It seems that these two gentlemen represented conflicting interests in some business concerning certain liabilities under the Workmen's Compensation Act. The Insurance Company having declined to pay Dr. Davies at the rate of a guinea a visit, this gentleman wrote to the secretary to the effect that their medical representative, the plaintiff in the present case, had tried to bribe him to betray his clients interests by suggesting that he should send in his bill to the Insurance Company. There does not appear to have been any ground for the statement, and at the suggestion of the judge, Dr. Davies unreservedly withdrew his allegations, whereupon the suit came to an end, but it would have been much more dignified if this course had been adopted before the case came into court.

THE latest suggestion for the treatment of chronic constipation in childhood is the administration of butter, which should be given in the natural state, and not in any vehicle. The dose, after the first month of life, is from one-half to a whole teaspoonful daily, increasing the quantity according to age.

The Popularisation of Cremation.

THE Corporation of Hull has inaugurated a movement which may ultimately bring about a revolution in the present method of the disposal of the dead in this country. We allude to their decision to popularise the system of cremation by reducing the fee, thus bringing this process within the reach of all classes. On payment of one guinea to residents, and three guineas to non-residents the Corporation have undertaken to carry out cremation of the dead in the city of Hull, this price will also include a plain urn and burial of the same. This movement inaugurated by the Hull Corporation is a step in the right direction. Cremation is undoubtedly a method of disposal of the dead which should be encouraged. So far, however, two drawbacks have hampered its progress. The first is that of sentiment, and this will probably for some time to come delay the general adoption of cremation. In the lower classes especially there is a great feeling in favour of a "beautiful" funeral; the trappings of woe are a service to the mourners, because of the display which is made of the means wherewith to pay for them. On the other, the cold, matter-of-fact, procedures associated with cremation are not such as to appeal to the feelings of those who look upon the pageant of a funeral in a family as of more importance than a marriage. The second drawback to cremation has been that of expense. The process has hitherto been a costly one, and, so far as the metropolis is concerned, no effort has been made to bring it within the reach of the classes. This is a mistake, for upon hygienic and sanitary grounds cremation is unquestionably the best method of the disposal of the dead. The late Sir Benjamin Richardson used to say that, from the point of view of the chemist, if this process were universally resorted to, the earth would be deprived of much of its ammonia from which nitrogen is evolved. But while no doubt this, in a measure, would be true, there is no reason to believe that the natural supplies of nitrogen would fail to fulfil the world's requirements in this respect.

The Mechanical Restraint of Lunatics.

ONE of the Commissioners in Lunacy, Dr. Needham, recently visited the Hampstead workhouse and found that the lunacy patients were at times subjected to mechanical restraint by means of belts and anklets. This infringement of the law was reported to the Local Government Board, with the result that the Guardians had received warning that the practice must forthwith be discontinued, and intimating that, failing compliance, steps would be taken to endorse the law. It has since transpired that the mechanical restraint was resorted to, forsooth, simply because the workhouse accommodation does not comprise a padded room. A less adequate excuse it would be difficult to imagine. Surely the Guardians are aware that a padded room is required by law, and is, therefore, a necessary adjunct to their institution? Why, then, should they shirk making legal provision for their lunatic inmates? It is reassuring to find that

the Local Government Board, through Dr. Needham, is alive to the duty of securing compliance with the law, and, under pressure, no doubt the recalcitrant Guardians will fall into line.

Soldiers' Teeth.

MR. WEIR, M.P., brought under the notice of the House of Commons, last week, the fact that a large proportion of the young men who offered themselves for enlistment, and who were passed as suitable, were afterwards rejected for bad teeth, and he asked the Education Department to provide dentists to supervise the dental condition of the boys attending the Board schools. Sir John Gorst, who answered him thought that the matter is one for the School Board, but we do not agree with him. If the purpose of the dental supervision is to preserve the rising generation in a condition suitable for military service, it is surely the business of the Government. In any case the cost of such supervision would be small, and the gain to the community outside the army great.

A. New Enterprise of the Liverpool School of Tropical Diseases.

NOT content with their enterprise in sending an expedition to Sierra Leone and the Gold Coast and Lagos, for the purpose of studying the malarial parasite, the Liverpool School of Tropical Diseases have now determined to send another expedition up the Niger, with the view of further investigating Major Ross's theory as to the transmission of malarial fever by means of the anopheles mosquito. Since the conditions of life on the oil rivers are somewhat different from those on other parts of the West Coast, it is hoped that this new expedition may yield valuable results.

The Royal Naval Medical Service.

IN introducing the Naval Estimates, Mr. Goschen last week stated that important changes in the Medical Service are impending. The number of the higher ranks of officers is to be increased and arrangements are being made to afford the junior officers increased opportunities for study at Haslar and at medical schools. A professor of tropical diseases is to be appointed for Haslar, and prizes are to be awarded to officers at the end of their period of study there.

Army Medical Instruments.

IT was announced by Mr. Goschen last week, when introducing the Naval Estimates, that a full allowance would be made, in future, to Medical Officers for their instruments. Heretofore these officers have had to "provide themselves" with instruments, and complaints have been made to the Admiralty that the supply has, in consequence, been rather stinted.

IT is stated that even including deaths from typhoid and dysentery in the besieged towns the total mortality from disease in connection with the war in South Africa does not exceed 600, to which, however, must be added a very much larger

number of deaths from wounds. This compares favourably with the experience of the United States Army in the Cuban campaign, where a fifth of all the soldiers in the principal camps contracted typhoid, and 7 per cent. of them died. It must be borne in mind, however, that the climate of Cuba is probably less congenial to the Anglo-Saxon temperament than that of South Africa, and it is hardly fair, moreover, to compare an old-established service like ours with the improvised medical service of the American Army Department.

AT the annual meeting of the Royal Medical and Chirurgical Society the president, Mr. T. Bryant, before opening the proceedings, remarked that if he were not presiding at a scientific society he would be tempted to ask the Fellows for three cheers in honour of the news from South Africa, a hint which the Fellows were not slow to act upon. It was evident that the feeling of satisfaction is not less keen among members of the profession than in the general public, though expressed in a less boisterous fashion—indeed members of the profession play too prominent a part in what Mr. Bryant elsewhere alluded to as “this miserable war” for their fellows to remain indifferent to their success.

ACCORDING to Dr. Clouston, superintendent of the Royal Edinburgh Asylum for the Insane, the proportion of cases of insanity directly attributable to alcohol, is 25·25 per cent., exactly the same proportion as that of the last five years. He remarked incidentally that the influenza was responsible for more cases of insanity than the emotions caused by the war and private losses put together.

NEW naval sick quarters, with a dispensary, are to be provided at Woolwich at an estimated cost of £12,000.

PERSONAL.*

SIR WM. MACCORMAC left Cape Town on Saturday last on the return journey.

CAPT. C. A. MAUNSELL, R.A.M.C., Administrative Medical Officer in Bombay, has been appointed Principal Medical Officer of the South-Eastern District.

DR. C. THEODORE WILLIAMS has been elected president of the Meteorological Society which this year celebrates its jubilee.

DR. SIDNEY RINGER, senior physician, and Mr. Christopher Heath, senior surgeon, to University College Hospital, will retire shortly in virtue of the age limit.

DR. JOSEPH HUNTER, one of the resident physicians in the Royal Infirmary, Edinburgh, has been accepted by the War Office as a civil surgeon, and starts for South Africa in a few days.

PROF. THOMAS JONES, M.B., F.R.C.S., of Manchester, has offered his services, which have been accepted by the authorities, to the Welsh Military Hospital, which is being established in South Africa.

MR. R. J. BREW, Superintendent of the administrative accounts in the office of the Registrar-General in Dublin, and second in command to Mr. M. Matheson, lately appointed as Registrar-General, has been appointed Assistant Registrar-General in his place.

HER Majesty the Queen personally bestowed on Thursday last the decoration of the Order of St. Michael and St. George upon Dr. Patrick Manson, Medical Adviser to the Colonial Office.

MR. VICTOR HORSLEY availed himself of the opportunity afforded by the dinner given by the Medical Society of Edinburgh yesterday (Tuesday) to deliver a speech on “The Medical Corporations.” We are not in possession of the terms of his remarks, but we can guess their tenour.

MR. ROBERT IRVINE, M.B., senior demonstrator of anatomy, Surgeons’ Hall, Edinburgh, who was lately accepted by the War Office for service in South Africa, was presented last week with two cases of surgical instruments on behalf of Dr. Whitaker and the students of the Anatomy Class at Surgeons’ Hall.

IN connection with the death of Dr. Wm. MacNeill Whistler, physician to the London Throat Hospital, which occurred in London last week, it will interest many to know that he was a surgeon in the Confederate Army during the American Civil War, and possessed both English and American diplomas.

ON the Queen’s visit to Netley Hospital last week, she was conducted through the wards and divisions by Major W. Dick, M.B., and Lieut.-Colonel W. E. Webb, M.D., Assistant Professors of Military Surgery and Medicine. Her Majesty spoke to the sick and wounded men, and made presents of flowers to those who were confined to their beds.

Scotland.

[FROM OUR OWN CORRESPONDENT.]

EDINBURGH’S WAR HOSPITAL.—Towards the £20,000 aimed at towards the formation of this hospital, £18,105 have been subscribed. Professor John Chiene, of the Edinburgh University has been offered and has accepted the post of civil surgeon in charge, and will be accompanied by his assistant, Mr. David Wallace, M.D., as second surgeon. Several junior Edinburgh men will form the staff, including Dr. George Chiene, the professor’s son. Professor Chiene’s resolve to serve his country at the seat of war on request is only what all who know him might have expected, and will assure the greatest possible efficiency in the surgical work of the hospital.

THE CHAIR OF PRACTICE OF PHYSIC IN EDINBURGH.—The question of who is to be the next occupant of the Chair of Cullen, Gregory, Alison, and other distinguished teachers of medicine continues to occupy the minds of the profession in Edinburgh. That Professor Osler has been approached in connection with the vacancy is generally an accepted fact, but how is he to act unless he enters as a candidate in the regular way is difficult to understand. The Curators of Patronage can hardly, in face of the standing of the other applicants, offer the post to one outside their ranks. Dr. Byrom Bramwell has distributed to members of the profession in Edinburgh, or connected with her school, copies of his letter of application, a wonderful record of work done, the sum of his published books and papers well-nigh reaching 200.

INFLUENZA IN EDINBURGH.—Influenza is still very prevalent in Edinburgh. A noteworthy fact about the present epidemic is the predilection the disease has shown for attacking the well-to-do classes. Not one case has been detected in any of the common lodging-houses in the city, while for some time after the commencement of the epidemic all the fatal cases which occurred were recorded in the south side suburbs, which are largely composed of villas and private houses. Latterly the West End has suffered, but the poorer parts of the city have experienced an almost complete immunity. Conversely, in several of the Infirmary wards patients of the class which has escaped outside have in many instances been attacked by the scourge while under treatment for other disease. Among members of the medical profession, Drs Muirhead, Watson, and P. MacLaren, and Professor Fraser, have all passed through more or less severe attacks, but have now, it is gratifying to be able to report, recovered or are convalescent.

EDINBURGH STUDENTS AND THE WAR.—The residents in the Edinburgh Infirmary have lost four of their number for service at the Cape in various posts. The equipment of the City War Hospital promises to detach others. Dr. Donald, a former Edinburgh University athlete, who was in practice in the city, has just left for South Africa, his services having been accepted by the War Office.

Obituary.

DR. BROOM, OF CLIFTON.

WE regret to announce the death of Dr. John Broom, at his residence Clifton, Bristol. Leaving a large and successful practice in Sheffield, he went to Clifton on account of his health in 1877. In 1883 he established the Bristol Institution for Skin and General Diseases, then in Nicholas Street. He was a Brussels graduate, holding also the L.R.C.P.I., and the L.R.C.S.Ed. Of attractive manners, he was popular both with his professional brethren and with his patients, by whom he will be greatly missed.

Literary Notes and Gossip.

THE *Archives of Pediatrics* will in future be edited by Dr. Walter Lester Carr, of New York, in whose hands a more successful career is anticipated for this publication.

A NEW edition of "Kirke's Physiology," edited by Dr. Halliburton of King's College, has just made its appearance. We are asked to announce that Dr. Ireland is preparing a new edition of his book on "The Mental Affections of Children."

A VERY pronounced effect of the war in South Africa is the paucity of new works in medicine and allied sciences. The autumn and winter, which is usually regarded as the season proper, has proved almost barren of new books, and we understand that with the exception of war literature there is absolutely no demand for books of any kind, so that publishers and the profession alike are suffering coincidentally with the nation at large.

IT is interesting to note that the word "Immune," which is included in the latest edition of the new "English Dictionary of Historical Principles," has been in use for six hundred years, although it is brand new in medical use. There is one class of old English words which has almost disappeared in this section, namely, the compounds in "i." In southern English they survived to the 15th century, when they were usually spelt with "y"—in which guise, "y-clad," "y-clept"—were handed down by the Elizabethan archaists.

THE eighth edition of Dr. Macnaughton-Jones's "Diseases of Women and Uterine Therapeutics" is announced to appear in a few days. We understand

that the work has been entirely re-cast, and is being issued in quite a new form. The rapid advances made in gynecology since the last edition appeared, have compelled the author to make considerable alterations, both in regard to discarded views and operations, as well as in view of the many important advances that have been made, especially in the field of operative gynecology. The book has been newly illustrated, and all the most recent models of instruments and appliances are figured.

THE first number, dated February 15th, has been issued of a new "Bibliographica Medica," devoted to the international bibliography of medical sciences on the model of the defunct "Index Medicus." The compilation will be edited by Professors C. Potain and Ch. Richet, of Paris, whose names afford some guarantee of accuracy and scientific method. The publication is to be issued monthly, like the "Index Medicus," and each number will contain a minimum of 4,000 references. The subscription has been put at 60 francs for foreign circulation (outside France) a figure which compares favourably with the £5 formerly charged for the American publication. We wish the venture every success and we regard the moderate cost as an important factor in securing it.

DR. ROBERT BELL, of Glasgow, has not been always fortunate in his relations with his brethren. He has now evolved a new idea, and has issued a book entitled "The Deputy Physician," for the benefit of the public at large. The medical journals are not honoured by receiving copies for review, and we know only of its existence from criticisms in the newspapers. Here is the opinion of the *Daily Chronicle* on the author's latest literary effort:—"This is a bad specimen of a bad class of book, and we fear that we cannot even endorse the author's description as given on the title-page, for it is not a guide to health, but rather an encouragement to tamper with health. In discussing the majority of his fellow-doctors, the author remarks that a little knowledge is a dangerous thing, and then at once proceeds to impart rather less than a little to the public, for whom the book is avowedly written."

NEW BOOKS AND NEW EDITIONS.

THE following have been received for Review since the publication of our last monthly list:—

BAILLIERE, TINDALL, COX, AND CO. (London and Paris.)

Treatise on Orthopaedic Surgery. By Ed. H. Bradford, M.D., Professor of Orthopaedic Surgery in Harvard University, and Robt. W. Lovett, M.D. Second Edition, with 621 illustrations. 655 pp. Price 18s.

Aids to Practical Pharmacy for Medical Students. New and revised edition. By A. Campbell Stark, Demonstrator of Materia Medica and Pharmacy at St. George's Hospital. Pp. 170. Price 2s. 6d.

Cancer et Tuberculose, par le Dr. Henri Claude. Pp. 94. Price 1s. 6d. cloth.

CHARLES GRIFFIN AND CO. LIMITED (London.)

The Flowering Plant as illustrating the First Principles of Botany. By J. R. A. Davis, M.A. F.C.P. 3rd Edition. Pp. 195. Price 3s. 6d.

HY. J. GLAISHER (London.)

Consumption: Its Nature and Treatment. By W. J. Spencer, M.A. M.D., M.R.C.P. Pp. 83. Paper cover.

H. K. LEWIS (London.)

A Manual of Gynecological Practice. By Dr. A. Dührssen, Professor of Midwifery, Univ., Berlin. Translated by John W. Taylor, F.R.C.S., Professor of Gynecology, Masons College, Birmingham, and Frederick Edge, M.D., Lond. F.R.C.S., Pp. 279.

Mentally Deficient Children. By G. E. Shuttleworth, B.A., M.D., 2nd Edition. Pp. 180. Price 5s. net.

LONGMANS, GREEN, AND CO (London.)

A Manual of Pathology. By the late Joseph Coats M.D. Fourth Edition, revised by Lewis R. Sutherland, M.B., Professor of Pathology in the University of St. Andrews. Pp. 1132. Price 31s. 6d.

SMITH, ELDER AND CO. (London.)

Saint Bartholomew's Hospital Reports. Vol. XXXV. Edited by Norman Moore, M.D., and D'Arcy Power, F.R.C.S. Pp. 246 and 356.

Literature.

SAVILL ON NEURASTHENIA. (a)

WE have here collected lectures delivered at the Paddington Infirmary and at Welbeck Street Hospital for Diseases of the Nervous System. The first lecture is largely taken up with a description of the general clinical material presented within the wards of a Poor-law infirmary. Undoubtedly, the opening of the Poor-law infirmaries of the Metropolis for clinical instruction with an aggregate of over 13,000 beds, is a step of immense significance in medical teaching, and Dr. Savill does well to recapitulate the very interesting types of disease there presented, and certain advantages here obtained over general hospitals and asylums. There is always the danger, however, that in making comparisons one may unduly exaggerate on one side or other; and when the author claims for the lunacy wards unique opportunities for the study of the beginning of mental alienation, we are afraid he is speaking rather late in the day, for the beginnings of mental alienation go further back. To say also that only chronic insanity can be studied in lunatic asylums is absurd. What about the cases which recover? With the remarks on specialism, methods of research, and clinical investigation, we have nothing to say. They are merely introductory. On the subject of the pathology of functional disorders of the nervous system the author gives six different ways in which they may be explained, and we are pleased to observe that he regards his views as largely a matter of hypothesis. We quite endorse his opinions that the term *hysteria* is too widely and indiscriminately used. The author does not believe in conscious, wilful stimulation of organic nervous disease, and he speaks from an extensive acquaintance with workhouse hospital cases and assures us that hysteria is quite as frequent among the poor and ignorant as among the wealthy and intelligent. The author's distinction between hysteria and neurasthenia will be found very helpful as a good deal of doubt and confusion prevails respecting this point. The succeeding lectures deal with the diagnosis and the pathology of neurasthenia, the mental symptoms of neurasthenia and neurasthenic insanity. There is much that is vague and indefinite in these lectures and a use of terms which we cannot reconcile with our experience. We had hoped to learn something new in regard to the relations of neurasthenia and insanity, but we confess to being disappointed. The author has, however, given some interesting clinical cases, and these speak for themselves. If they had been more succinctly stated and classed together apart from the general text, they would be useful as references for busy medical men. These lectures have diligently grappled with a difficult subject.

LES ARMES BLANCHES. (b)

THE two army surgeons, the authors of this work, have compiled a very practical as well as scientific account of wounds produced by "cold steel." The cavalry sabre is taken as the type of a cutting weapon, and the wounds it may cause in various regions and to different tissues are fully described, many cases being quoted in illustration. The remainder of the book is devoted to pointed weapons. First the bayonets of different nations are described, then a long, exhaustive account is given of the wounds they may cause in all parts of the body, together with the diagnosis, prognosis, treatment, &c., of such wounds; next, the lesions produced by the point of the infantry sword, by the duelling sword, and by the lance are considered; a brief chapter is devoted to wounds made by poisoned arrows, upon which some hints are given which would prove of great use in savage warfare. The book terminates by a few words about defensive armour; the helmet and the cuirass are only mentioned as relics of the time when battles were decided with

(a) "Clinical Lectures on Neurasthenia." By Thomas D. Savill, M.D. London: Henry J. Glaisner. 1899.

(b) "Les Armes Blanches, leur action et leurs effets vulnerants." By Drs. Nimier and Ed. Laval. Paris: Felix Alcan, Editeur. P. 435.

"cold steel," but mention is made of the modern idea consisting of a metal screen giving a more or less certain shelter from bullets. There is no doubt that all naval or military surgeons having a knowledge of French would find a great amount of interest and instruction in the pages of this book.

Laboratory Notes.

CHINOSOL TABLETS.

THE antiseptic and deodorant properties of chinisol in surgical practice and general hygiene are pretty generally recognised and appreciated, but its value as an internal antiseptic is less known. We have been favoured by Mr. Kühn with a sample of the five-grain Chinisol Tablets which are especially intended for internal administration. Given the well-authenticated antiseptic and anti-fermentative potency of this substance, and in view of its innocuousness and absence of causticity, we can quite imagine that its effects in arresting gastro-intestinal fermentation would be marked. In typhoid fever the benefits to be derived from an anti-putrefactive medication are well known, and the special properties of chinisol seem to mark it out for a careful trial on these lines. The dose of chinisol for internal administration is five grains three times daily, taken either dissolved in water or (crushed) in cachet form.

Added to impure water it effectually destroys pathogenic organisms, but in view of the announcement that a large supply of the tablets has been sent to Durban, we doubt whether the average British soldier will consent to "chinolise" his drinking water merely to avoid typhoid fever or dysentery.

CHLORETONE.

CHLORETONE, the new hypnotic, analgesic and anæsthetic, introduced by Messrs. Parke, Davis and Co., is a fine white crystalline compound resulting from the interaction of chloroform, acetone and an alkali. It is sparingly soluble in cold water, but is very stable. The average dose is from 6 to 18 grains, preferably given in cachets or in the form of sugar-coated tablets, each of which contains three grains. A saturated solution of chloretone, used in the same way as cocaine and eucaine, exerts similar anæsthetic properties. Experimentally, in animals, it has been successfully employed as a general anæsthetic, the quantity required being about 3½ grains per kilogramme of body weight. This application does not appear to have been so far tried on human beings. It is specially recommended in the treatment of insomnia, and as an analgesic in gastralgia and vomiting. It is stated not to depress the circulation "materially," even in comparatively large doses, and its action is claimed to be restricted to the cortical nerve cells.

Medical News.

Dublin Health.

THE death-rate of Dublin, which had fallen to 29.1 per 1,000 of the population, has risen again to 51.0. This apparently heavy increase has arisen from the inclemency of the weather, which has run up the deaths from respiratory disease to a phenomenal number, 94 of such deaths are recorded, being 37 above average, and 20 above last week. It is also pointed out that the figures for this week are made to look much worse by the neglect of the authorities of the South Dublin Union to register their deaths in due time. No less than 51 of the deaths now registered occurred in the workhouse before February 17th.

St. Thomas's Hospital House Appointments.

THE following gentlemen have been selected as house officers from Tuesday, March 6th, 1900:—

House Physicians: H. R. Beale, L.R.C.P., M.R.C.S., L. S. Dudgeon, L.R.C.P., M.R.C.S., B. F. Howlett,

L.R.C.P., M.R.C.S. (extension), and F. H. Ellis, B.A., M.B., B.C., Cantab., L.R.C.P., M.R.C.S. (extension).

Assistant House Physicians: E. W. Hedley, M.A., M.B., B.C., Cantab., and F. C. Eve, B.A., M.B., B.C., Cantab.

House Surgeons: A. Webb Jones, L.R.C.P., M.R.C.S., E. A. Gates, L.R.C.P., M.R.C.S., E. C. Bourdas, L.R.C.P., M.R.C.S., and N. Unsworth, L.R.C.P., M.R.C.S.

Assistant House Surgeons: A. E. Martin, B.A., M.B., B.C., Cantab., L.R.C.P., M.R.C.S., J. F. Cunningham, L.R.C.P., M.R.C.S., and Y. Takaki, L.R.C.P., M.R.C.S.

Obstetric House Physicians: (Senior) H. H. R. Clarke, L.R.C.P., M.R.C.S., and (Junior) A. Bevan, L.R.C.P., M.R.C.S.

Ophthalmic House Surgeon: (Senior) J. E. Kilvert, L.R.C.P., M.R.C.S.

Clinical Assistants in the Special Department for Diseases of the Throat: S. H. Belfrage, M.B.Lond. (extension), and S. A. Lucas, L.R.C.P., M.R.C.S. Skin: R. B. Kinloch, L.R.C.P., M.R.C.S., and J. C. W. Graham, B.A., Cantab., L.R.C.P., M.R.C.S. Ear: G. I. T. Stewart, M.A., M.B., C.M., Aberd.

Medical Defence Union.

THE Annual General Meeting of the Medical Defence Union will be held on Tuesday, March 13th, at St. Martin's Town Hall, W.C., at 4 p.m. The chair will be taken by Dr. Griffith, F.R.C.P., the President of the Union.

Royal Medical and Chirurgical Society of London.

At the Annual General Meeting, on Thursday, March 1st, the following were elected officers for the ensuing year:—

As President: Frederick William Pavy, M.D., F.R.S.

As Vice-Presidents: Sydney Ringer, M.D., F.R.S., Charles Theodore Williams, M.D., Henry Greenway Howse, M.S., Henry Morris, M.A., M.B.

As Honorary Treasurers: William Selby Church, M.D., J. Warrington Haward.

As Honorary Secretaries: Thomas Barlow, M.D., Alfred Pearce Gould, M.S.

As Honorary Librarians: Norman Moore, M.D., Rickman J. Godlee, M.S.

The Medical Sickness and Accident Society.

THE usual monthly meeting of the Medical Sickness Annuity and Life Assurance Society was held at 429, Strand, London, W.C., on February 23rd. There were present Dr. de Havilland Hall, chairman; Dr. J. B. Ball, Dr. Walter Smith, Mr. F. S. Edwards, Dr. J. Pickett, Mr. William J. Stephens, Dr. M. Greenwood, Mr. J. Brindley James, Dr. J. W. Hunt, Dr. W. Knowsley Sibley, and Mr. Edward Bartlett. As is usual at this time of the year, the list of current sickness claims was very long. A large number of the illnesses have been caused by influenza and by the bronchial affections which are so prevalent in the early spring, and to which medical men, especially those in country practice, are particularly liable. About one-third of the whole number of current claims are cases in which there is little hope that the members will be ever again able to resume practice. In these cases the continuous half-pay of the society forms a very valuable provision. Prospectuses and all particulars on application to Mr. F. Addiscott, sec., Medical Sickness and Accident Society, 33, Chancery Lane, W.C.

THE annual general meeting of the Irish Medical Schools' and Graduates' Association will take place at the Hotel Cecil on March 17th, at 6.30 p.m., and on the same evening the Association will dine at 7.15. Inspector-General W. H. Lloyd, M.D., in the chair.

The Viavi Fraud.

AN inquest was held at Eastbourne a few days since on a young married woman who had died somewhat suddenly after taking the remedies of a commercial concern known as the "Viavi" Company. It transpired that death was due to the rupture of a duodenal ulcer, but the jury, in returning a verdict of death from natural causes, added an expression of opinion, based on the evidence given before them, that the "Viavi" Company was a fraud. A "Dr." Woodward, who claims to

hold a medical qualification granted by the University of Pennsylvania, stated that he was the "overseer" of the medical department of the company.

University of Durham Faculty of Medicine.

THE Secretary of State for War, having availed himself of the powers conferred upon him by Royal Warrant, recently offered to the University of Durham three nominations to the Royal Army Medical Corps, which have been filled by the following gentlemen:—Mr. James Andrew Hartigan, Mr. Charles S. Smith, and Mr. Harold Ben Fawcett, all of whom are graduates in medicine and surgery of the university. It may be also mentioned that Surgeon-Captain Marford, who accompanies the South African Battery of the 1st Northumberland Volunteer Artillery, and Surgeon W. L. W. Walker, who has been attached to one of the South African Companies of the Northumberland Yeomanry are also graduates of Durham. Of the present and former students of the University of Durham College of Medicine, eight have volunteered for service in South Africa, and are either at the front or on their way there.

Royal Army Medical Corps.

MR. POWELL WILLIAMS, in reply to Captain Norton, who suggested the advisability of organising a special staff of night orderlies, who would be excused day duty as in all large civil hospitals, in order that the sick or wounded soldier might be at least as well attended to as the civilian patient, said that the question had been very carefully considered, and in view of the number of experienced men of the Medical Staff Corps, who have applied to re-enlist, and by whose help the pressure will be greatly diminished, it is not thought expedient to form the special staff suggested.

THE Church Missionary Society has received an anonymous donation of £8,000, one-fourth of which is to be expended on medical missions.

THE death is announced of Thomas Guy, M.D., F.R.C.P., Inspector-General of Army hospitals, in his 81st year. His father and grandfather were both members of the medical profession, and he was the brother of Dr. William Guy, F.R.S. Dr. Guy, in 1870, translated into English Esmarch's "First Dressing of Wounds on the Battlefield."

Vital Statistics.

THE deaths registered last week in thirty-six great towns of England and Wales corresponded to an annual rate of 27.5 per 1,000 of their aggregate population, which is estimated at 12,784,802 persons in the middle of this year. The deaths registered in each of the last four weeks in the several towns, alphabetically arranged, corresponded to the following annual rates per 1,000:—

Birkenhead 24, Birmingham 22, Blackburn 37, Bolton 24, Bradford 21, Brighton 23, Bristol 18, Burnley 29, Cardiff 13, Croydon 9, Derby 22, Dublin 51, Edinburgh 25, Glasgow 35, Gateshead 23, Halifax 26, Huddersfield 21, Hull 22, Leeds 29, Leicester 20, Liverpool 33, London 21, Manchester 34, Newcastle-on-Tyne 25, Norwich 25, Nottingham 21, Oldham 33, Plymouth 27, Portsmouth 18, Preston 44, Salford 39, Sheffield 27, Sunderland 22, Swansea 17, West Ham 17, Wolverhampton 40.

Her Majesty's Navy Medical Service.

THE undermentioned gentlemen, who competed on February 19th, 1900, and following days at Examination Hall, Victoria Embankment, for appointment as Surgeon in the Royal Navy, have been granted commissions:—

Name.	Marks.	Name.	Marks.
H. E. C. Fox, M.B....	2,436	H. R. H. Denny ...	2,028
J. G. Wallis, M.B....	2,334	R. B. Ainsworth ...	2,020
W. P. Walker, M.B.	2,320	J. H. J. Murphy ...	2,005
R. W. G. Stewart,		A. J. Hewitt ...	1,950
M.B. ...	2,270	G. M. Eastment ...	1,901
J. O'Hea ...	2,258	H. J. Rogers, B.A.,	
R. R. Fasson, M.B.	2,234	M.B. ...	1,883
J. R. Muir, M.B. ...	2,211	A. C. Renwick, M.B.	1,873
L. S. Whitwam, M.B.	2,173	W. P. Dyer ...	1,846
A. F. Fraser, M.B....	2,098	T. H. Vickers ...	1,806
A. S. Frank, M.B. ...	2,041	R. R. Horley ...	1,717

Notices to Correspondents, Short Letters, &c.

✎ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

MR. W. A. SMITH.—Your faith in the drug you mention as a remedy for whooping cough may or may not be well founded. In other words, your experience may be such as to furnish good ground for inference or rational belief. Whether the causal sequence will hold good or otherwise upon further consideration is for you to examine for yourself. Before you can expect any scientific body to accept your conclusions, however, we need hardly remark that you will have to prove your position to full demonstration. You will have, for instance, to produce a number of cases so large as to exclude mere coincidence in the cures. Cases will also be required treated by other methods, and, if available, those treated without drugs. If, after most searching examination, you can demonstrate that the administration of your new remedy, and the cure of whooping cough stand in the relation of cause and effect you will have conferred a benefit upon humanity, and will be justified in publication.—*Festina lente.*

E. T. R.—Sharp pain at the instant of ejaculation may be due to impingement of the semen upon the mouth of the duct, pathologically narrowed by posterior gonorrhoeal urethritis, but the presence of a congestive stricture in the penile urethra will also give rise to pain, localised to the strictured part. In some cases the narrowing of the ejaculatory duct may be so marked as virtually obliterate the passage, and, if bilateral, sterility is the result.

JAPAN TO THE FORE IN TUBERCULOSIS?

We cull the following from a recent number of the *Sei-Kwai* medical journal, in the English language of that journal:—"Fleet-Surgeon T. Yabe, of the Imperial Japanese Navy, who is now studying bacteriology in the Pasteur Institute, Paris, discovered some method to make human subjects *immune from the tubercular disease* with some material which he calls *Tuberculo-Immunitine*. We heartily congratulate his success for such great and difficult subject which was considered almost impossible to achieve at among the imminent authorities in Europe and America."

Meetings of the Societies and Lectures.

WEDNESDAY, MARCH 7TH.

OBSTETRICAL SOCIETY OF LONDON.—8 p.m. Specimens will be shown by Mr. G. W. B. Lawrence (introduced by Dr. Blacker). Dr. Macnaughton-Jones, and others. Demonstration:—Mr. A. Keith (introduced by Dr. Lewers): Dropsical Parasitic Twin Fetus of Peculiar Form. Paper:—Dr. J. Phillips: A Case of Extra-uterine Gestation in which Fetal Death occurred at Term after Spurious Labour and Abdominal Section was performed from four to five months later.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 p.m. Prof. A. W. Mayo Robson: The Surgery of the Stomach.

THURSDAY, MARCH 8TH.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.—8 p.m. Cases and Card Specimens. 8.30 p.m. Papers:—Mr. W. M. Beaumont: Family Tendency to Ophthalmoplegia Externa.—Mr. A. Q. Silcock: Meningitis followed by Panophthalmitis.—Mr. J. H. Fisher: Pigmented Tumour of the Eyeball, Death from Multiple Pigmented Carcinomata nearly 14 years after Excision of the Eye.—Mr. H. W. Dodd: Green Vision.—Mr. W. H. Jessop: Embolism of both Central Retinal Arteries.

MEDICAL SOCIETY OF LONDON (Whitshall Rooms, Hotel Metropolitan).—7 p.m. Anniversary Dinner.

BRITISH GYNECOLOGICAL SOCIETY (20, Hanover-Square, W.).—Specimens will be shown by Mr. S. Bishop, Dr. G. Elder, and Dr. Macnaughton-Jones. Papers: Dr. R. Worrall: Pregnancy complicated with Myomata and Ovarian Cyst.—Dr. M. Laurie: The Indications for the Removal of the Uterine Appendages.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.—5 p.m. Dr. F. J. Waldo: Summer Diarrhoea with special relation to Causation and Prevention. (Milroy Lecture.)

FRIDAY, MARCH 9TH.

CLINICAL SOCIETY OF LONDON (20, Hanover-Square, W.).—8.30 p.m. Papers:—Dr. Caton: The prevention of Valvular Disease in Acute Rheumatism.—Dr. Hale White and Mr. Frigg: A Case in which the attempt was made to Remove a Dermoid Tumour which, growing in the Spinal Canal, pressed upon the Spinal Cord.—Dr. F. E. Batten and Dr. Prickett: A Case of Acute Encephalitis in a Child following Infantsia.

BRITISH LARYNGOLOGICAL, RHINOLOGICAL, AND OTOLOGICAL ASSOCIATION (11, Chandos Street, Cavendish Square, W.).—4.30 p.m. Discussion on Condition of the Throat and Larynx Simulating and Predisposing to Tuberculosis (opened by Mr. Lennox Browne).

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 p.m. Prof. A. W. M. Robson: The Surgery of the Stomach.

ROYAL INSTITUTION OF GREAT BRITAIN.—9 p.m. Prof. F. Clowes: Bacteria and Sewage.

SATURDAY, MARCH 10TH.

ROYAL INSTITUTION OF GREAT BRITAIN.—3 p.m. Right Hon. Lord Rayleigh: Polarised Light.

Appointments.

DUNLOP, THOMAS, M.B., C.M. Edin., D.P.H. Camb., Medical Officer of Health to the Aldershot Urban District.

HEBBLETHWAITE, ALFRED G., M.R.C.S., L.R.C.P. Lond., appointed Public Vaccinator for Keighley and District.
LIMINGTON, W. W., F.R.C.S. Eng., Honorary Assistant Medical Officer to the Victoria Hospital, Folkestone.
O'BRIEN, D. P., L.R.C.P. Irel., L.R.C.S., F.R.C.S., Irel., Government Medical Officer at Ravenswood, Queensland.
STEGMANN, ED. J., M.B., D.P.H., Assistant Lecturer on Hygiene and Public Health at St. Mary's Hospital Medical School, London.
VICKERS, CHARLES W., M.R.C.S., L.R.C.P. Edin., L.S.A., D.P.H. Lond., Medical Officer of Health for Paignton (Devonshire).
WAUGH, J., M.D. Dub., Medical Officer for the Leighton Buzzard Union.

Vacancies.

Cardiff Infirmary.—Resident Medical Officer. Salary £100 per annum, with board, washing, and apartments. Also an Assistant House Physician for six months. Salary at the rate of £50 per annum, with board, washing, and apartments.
Castleberg Union. Medical Officer. Salary £100, and £15 per annum as Sanitary Officer, with the usual Vaccination Fees. Applications to W. Hamilton, Clerk of the Union. (See Advt.)
Cumberland and Westmorland Asylum, Garlands, Carlisle.—Junior Assistant Medical Officer, unmarried. Salary £100 a year, with board and residence.
Devon County Asylum, Exminster.—Third Assistant Medical Officer. Salary £100, rising to £125, with board and residence.
Durham County Asylum.—Assistant Medical Officer. Salary, commencing at £140, with board, lodging, washing, &c. Apply to Medical Superintendent, Winterton, Ferryhill.
Great Northern Central Hospital, Holloway, London.—Junior House Surgeon for six months. Salary at the rate of £30 per annum, with board, lodging, and washing in the hospital. (See Advt.)
Hants County Asylum, Fareham.—Third Assistant Medical Officer, unmarried. Salary commencing at £125 per annum, with apartments, board, washing, and attendance.
King's College, London.—Professorship of Materia Medica and Therapeutics.
Newport and Monmouthshire Hospital, Newport, Mon.—House Surgeon. Salary £100 per annum, with board and residence. No stimulants provided.
Nottingham General Hospital.—Assistant House Physician for twelve months. Salary £100, with board, lodging, and washing in the hospital.
Royal Surrey County Hospital, Guildford.—House Surgeon and Assistant House Surgeon. Salary, House Surgeon, £80 a year, with board, residence, and laundry. Salary, Assistant House Surgeon, £30 a year, with board, residence, and laundry.
Royal National Hospital for Consumption, Ventnor, Isle of Wight.—Resident Medical Officer. Salary £150 per annum, with board and lodging, and the assistance of a clinical assistant and a dispenser. Immediate applications to Dr. Parry at the Hospital. (See advt.)
Sheffield Royal Hospital.—Two Assistant House Surgeons (Senior and Junior), unmarried. Salary £50 each per annum, with board (exclusive of wine and beer), washing, and lodging.

Births.

HINDS.—On March 1st, at 14, The Steyne, Worthing, the wife of Frank Hinds, M.D., of a son.
WICKHAM.—On Feb. 25th, at Chernock House, Fleet, Hants, the wife of Gilbert H. Wickham, M.B. Cantab., of a son.

Marriages.

FESTING-SMITH—DE COURCY.—On Feb. 27th, at St. Stephen's-by-Saltash, Alfred C. Festing-Smith, L.R.C.P., F.R.C.S., of St. Budeaux, to Esther Eleanor, eldest daughter of Lord and Lady Kingsale, of Stoketon, Saltash.
GRIFFITH—WELCHMAN.—On Feb. 27th, at Cullompton, Alfred Hume Griffith, M.B., Ch.B., second son of the late Rev. E. Moule Griffith, B.A., to Mary Eliza, only daughter of George Welchman, Esq., of Cullompton.
HOLLIS—LASSELL.—On Feb. 27th, at St. John's Wood Presbyterian Church, Harry Hollis, M.D. Cantab., of Wellingborough, to Eleanor, third daughter of the late William Lassel, jun., of Liverpool.
MOLONY—HIGGINSON.—On Feb. 27th, at Great Connell Church, Kildare, John Molony, F.R.C.P., son of the late Charles B. Molony, Esq., to Mary Macaulay (May), second daughter of the late Charles H. Higginson, Esq., of Springmount, co. Antrim.
STOWE—BROWNE.—On Feb. 27, at St. Paul's, Wellington, New Zealand, by Bishop Wallis, W. Reginald Stowe, M.R.C.S.E., eldest son of Leonard Stowe, of Tikiwai, Wellington N.Z., to May, eldest daughter of Wm. Lyon Browne, of Church Stretton, Shropshire.

Deaths.

DUKE.—On Feb. 22nd, at Villa Albert, Cannes, Frank Douglas William Duke, M.R.C.S., aged 51.
GUY.—On March 2nd, at Dover, Thomas Guy, M.D., F.R.C.P., Inspector-General of Army Hospitals (retired), in his 81st year.
HEATHER.—On March 2nd, at the Royal Naval Hospital, Plymouth, Benjamin G. Heather, B.N., M.R.C.S., L.R.C.P., aged 30 years.
SCATTERGOOD.—On Feb. 22nd, at Park Square, Leeds, Thomas Scattergood, M.R.C.S., L.S.A., aged 74 years.
WEARING.—On March 2nd, at Mayfield, Victoria Park, Liverpool, Richard Wearing, M.D. Ed., aged 46 years.
WHISTLER.—On Feb. 27th, at 6, Bickenhall Mansions, Gloucester Place, London, William MacNeill Whistler, M.D., late surgeon to the United States Army, U.S.A., aged 63.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXX.

WEDNESDAY, MARCH 14, 1900.

No. 11.

Original Communications.

THE ANATOMY AND PATHOLOGY OF THE RARER FORMS OF HERNIA (a)

By B. G. A. MOYNIHAN, M.S.LOND.,
F.R.C.S.ENG.,

Assistant-Surgeon, Leeds General Infirmary; Consulting Surgeon,
Skipton and District Hospital.

BILOCULAR HERNIA, INCLUDING INGUINO- PRO-PERITONEAL AND CRURO-PROPERI- TONEAL HERNIA, AND INTERSTITIAL HERNIA.

THE term "pro-peritoneal hernia" is reserved for those cases which fulfil the following conditions:—1. The hernial sac has two loculi. 2. The inner loculus lies between the peritoneum and the fascia transversalis. (Fig. 1.) 3. The outer loculus lies in the inguinal or crural ring, or in rare cases between the layers of the abdominal wall. 4. Both loculi open into the abdomen by a single orifice, the "ostium abdominale." By an interstitial hernia is understood a hernia which fulfils the following conditions:—1. The hernial sac has two loculi. 2. The inner upper loculus lies (a) between the internal and external oblique, or (b) between the external oblique and the skin. 3. The outer lower loculus lies in the inguinal canal. 4. The upper loculus opens into the lower, in some cases close to, in other cases a little distance from, the internal abdominal ring.

All these forms of hernia might, with advantage, be included under the title "bilocular hernia," a name which is appropriate and accurate. The term "bilocular" is applied to a form of hydrocele which is probably very closely related, from the developmental point of view, with these forms of hernia. The apt terms "intraparietal," "interparietal," and "extraparietal" for the sacs within, between and outside the muscles, are employed by Rose and Carless.

In pro-peritoneal hernia the inner sac may have one of three positions:—1. It may pass upwards and outwards from the internal abdominal ring to the anterior superior spine. 2. It may pass directly backwards and occupy the inner part of the iliac fossa near the brim of the pelvis. 3. It may pass downwards and inwards into the true pelvis lying by the side of, or in front of, the bladder. Variety I. has been described as hernia inguinalis intrailiaca, Variety III. as hernia inguinalis antevesicalis (St. Bartholomew's Museum, 2118).

The outer or lower sac may be within the inguinal canal, or have reached the scrotum, or in rare cases may be interstitial. The right side is more commonly affected than the left. In a striking proportion of the recorded cases there has been more or less imperfect descent of the testicle. The history of

some of Breiter and Krönlein's cases show that at birth, or very shortly afterwards, a hernia was noticed, and many of the patients had, for months or years, been accustomed to the wearing of a truss. Most frequently the hernia on examination has been found to be congenital. In fifty-nine cases the sac was congenital in thirty-six: in thirteen no mention was made of this point. In ten only is it definitely asserted that the position of the testis was normal.

ETIOLOGY OF PRO-PERITONEAL HERNIA.

The various theories which have been suggested as explaining the development of these forms of hernia may be tabulated, for the sake of clearness, in the following manner.

A.—1. The scrotal sac is first developed, the interstitial sac being secondary, and arising from the loosening and progressive bulging at the neck of the sac. This may result from cicatricial narrowing of the ostium abdominale, whereby the return of the bowel is impeded (Gosselin; Struebel). "Cicatricial narrowing" of the neck of the sac is freely spoken of in the description of cases and operations. I am disposed to doubt whether it ever occurs, and I am convinced that if it does occur it is only very rarely. Since the introduction of Bassini's, Halsted's and other operations necessitating the opening up of the inguinal canal, the precise conditions existing at the upper part of the intra-canalicular portion of the sac have been more readily and more closely studied. It may, I think, be said that dense induration at the neck of the sac is never observed. 2. Repeated, indiscriminate, and unrestrained taxis on the part of the patient (Streubel). 3. The wearing of inefficient and ill-fitting trusses, which make pressure, not upon the whole canal, but upon the external ring only (Streubel). 4. Irregularity of the developmental process owing to incomplete descent of the testis (retentio iliaca, retentio inguinalis, retentio pubo-scrotalis) whereby the descent of the gut is barred. Impulses from above continuing, the bowel is forced laterally (Streubel; Krönlein). 5. Narrowing of the external ring, while the canal is wide. The bowel readily enough enters the canal, but cannot pass the external ring, and therefore insinuates its way between the layers of the abdominal wall (Mosetig v. Moorhof). 6. Through traction of the omentum when adherent to the neck of the sac (Janzer).

B.—The scrotal sac develops first. Owing to the uncontrolled application of taxis the whole sac is returned between the peritoneum and the fascia transversalis. Later intra-abdominal pressure or other cause leads to the development of a second hernial sac from the parietal peritoneum in the neighbourhood of the internal abdominal ring (Tessier).

C.—The pro-peritoneal sac is first developed as a diverticulum from the parietal peritoneum. A secondary bulging of a part of this sac may extend down the inguinal canal into the scrotum (Linhart; Baer).

D.—The scrotal sac and the pro-peritoneal sac are

(a) Abstract of the First Arris and Gale Lecture, delivered before the Royal College of Surgeons of England.

two originally distinct pouches from the parietal peritoneum. The gradual enlargement of either causes its encroachment upon the other, until the two sacs eventually unite and open into the abdomen by a single orifice (Baer). In this connection it is worthy of remark that in an inaugural dissertation, written in 1883, Wagner relates a case where an ordinary oblique inguinal was found. On the outer side of the hernia, opening into the peritoneal cavity by a separate orifice, was a pro-peritoneal hernia.

E.—The hernia results essentially from an outward dislocation of the internal abdominal ring. As a result of this displacement the cord would be insufficient in length to reach the bottom of the scrotum, retention of the testicle would result and a hernia would be formed in the displaced upper portion of the inguinal process. To account for this dislocation, a "faulty insertion of the inguinal band of the primordial kidney on the abdominal wall" is supposed (M. Schmidt).

F.—The pro-peritoneal sac results from the dilatation of the funicular process between its origin and its entrance into the canal ("first portion" of Eppinger), at which point there is generally a more or less well defined constriction; the interstitial sac results from the dilatation of that part inside the canal (Ramonède).

It is probable that many causes are at work leading to the development of this variety of hernia. There is no doubt that in certain cases, probably the majority, a congenital defect is at the root of the matter. Many years ago Rokitsky pointed out that in the inguinal region, in the immediate neighbourhood of the internal abdominal ring, small pouches or diverticula were not uncommon. These can occasionally be seen even in the adult or in the aged, but I have seen them at their best in the foetus. I find that the most effective method of examination is to lay the subject on the face, remove the sacral, lumbar, and lower dorsal vertebrae, and all the abdominal contents, and expose in this way the anterior abdominal wall from behind. If this be done a fossa or fossæ can be seen clearly defined in at least 20 per cent. of bodies. Moreover, a fossa can occasionally be found (I have seen two striking examples) along the outer side of the hypogastric artery, which in such cases raises up a well-defined fold of peritoneum, a sort of mesentery. It is at least probable that these pouches offer facilities for the involvement of omentum or bowel in them.

With regard to the origin of these small pouches of Rokitsky, it has occurred to me that the explanation given by Lockwood for the origin of the sac of an infantile hernia may be applicable here. As is generally known, this author considers that an aberrant attachment of the gubernaculum is responsible for the abnormal descent of the peritoneum forming the sac. If the gubernaculum can cause the descent of a peritoneal tube into the scrotum, it seems reasonable to suppose that, acting with less completeness, the mere pouching seen in foetuses might very readily result. The area of peritoneum bearing these pouches is precisely that which is in intimate connection with the gubernaculum, and this fact is, to say the least, suggestive.

It may, then, I consider, be taken for granted that the congenital defect leading to the formation of the pouches described by Rokitsky, and possibly also the pouches developed by the side of the obliterated hypogastric, is in some degree responsible for the onset of pro-peritoneal hernia.

A further congenital defect commonly associated, as I have mentioned, with pro-peritoneal hernia is imperfect descent of the testis. This may be the primary defect, and give rise to the development of the necessary sac by acting as a barrier to the further descent of the hernial swelling, or it may be second-

dary and result from the cause, outward dislocation of the internal ring, or another, of the hernia.

The "reduction in mass" of a hernia has been supposed by Tessier and others to be capable of laying the foundation of a pro-peritoneal hernia. Theoretically there is no objection to this suggestion, but practically it lacks sufficient confirmation. I shall presently endeavour to show that it is not unlikely that the condition known as "reduction in mass" is in one of its forms very closely allied to, if not identical with, some forms of pro-peritoneal hernia. The evidence as to the causation of inguino-pro-peritoneal hernia may be thus stated:—

1. The hernia arises most frequently as the result of some congenital abnormality in the inguinal region; as an added factor there may be a loosening, congenital in origin (Linhart), of the peritoneum in this region.

2. In some examples a more or less complete "reduction in mass" may be the original and responsible factor.

3. In a few cases the inner sac may be first fully formed, and the inguinal sac is then a secondary diverticulum; or possibly two sacs originally distinct may, by gradual enlargement and mutual encroachment blend at or near the ostium abdominale.

Cruro-pro-peritoneal hernia may, almost or quite, without exception, be said to be dependent upon the existence of congenital peritoneal pouches. The case of Mr. Knaggs is a most admirable example of this.

ETIOLOGY OF INTERSTITIAL HERNIA.

Much that has been said of pro-peritoneal hernia applies with equal weight to interstitial hernia. The pouches of Rokitsky cannot, of course, stand in any causal relationship. The portion of the funicular process from which the diverticular sac is formed is either the "third portion" of Eppinger or the portion immediately outside the external oblique. Anomalies of the testis are noticed with even greater frequency in interstitial than in pro-peritoneal hernia.

The most satisfactory explanation of the development of interstitial hernia is, I venture to think, founded upon the connection of the hernia with retained testis. The testis bars the way to a further descent of the hernia, and the inguinal portion of the sac bulges out in the direction of least resistance. This explanation is strengthened by the observation, which is almost universal, that the scrotum is hardly ever fully occupied by a sac containing bowel or omentum. As a general rule the lowest point reached by the descending hernia is at or just outside the external abdominal ring. An exquisite example of this is found in the Guy's Museum, No. 1,120. The bulging sac behind the barrier-like testis held "nearly a foot of ileum."

In some cases, however, the testis is normal in position, and the explanation given is therefore inapplicable to them and to the cases occurring in women. There is one explanation, however, which, although I do not think it adequately accounts for these cases, is still deserving of recognition. In the earlier records there is occasional mention of the "thinness" of the abdominal wall in the inguinal region, of "obliteration of the layers," and so forth; but, so far as I am aware, it is to Macready that we owe the assertion of the importance of this condition. He has shown that "the wasting or congenital defect of the muscles is chiefly noticeable below a horizontal line through the anterior superior iliac spine. It concerns sometimes the external oblique as well as the deeper muscles. In a greater or less degree it seems to be a constant feature in the interstitial hernia now under consideration."

I cannot do better than quote the following passage from Macready's "Treatise on Ruptures":—

"If we seek for the principal difference between

interstitial and those herniæ with anomalies of the testis, we find it in the condition of the parietes. I have drawn attention to the delicate membranous state of the abdominal walls about the inguinal region. Here is a difference between interstitial and other herniæ which is common and which is real. If the imperfection of the abdominal wall, so often noticed with these herniæ as existing in greater or less degree, is their original cause, it does not militate against the supposition that a large proportion are attended with anomaly of the testis. On the contrary, when that organ is defective, it is very probable that the parts through which it passes, and with which it is so intimately related, will be likewise deficient, more especially as the anomaly of the testis in these cases is generally of a high grade."

It must, however, not be forgotten that this muscular atrophy and thinning may in some cases be the result rather than the cause of the hernial formation. The weight of a large hernial mass, constantly pressing unduly on the muscular wall, may lead to its wasting or disappearance. Macready does not bring forward any arguments which seem to me convincing in support of his view. I should certainly be disposed to consider the wasting of the muscles which undoubtedly exists rather as an effect than as a cause of the hernia.

In that class of case in which the mural sac lies between the external and internal oblique, if the external muscle be firm and the internal and transverse be thin and atrophied, the resistance met with at the external ring would cause a bulging beneath the aponeurosis of the external oblique. The condition in which the sac lies upon the external oblique may be caused by a testis retained immediately outside the canal, or possibly by the misapplied pressure of a truss, apart altogether from any irregularity, congenital or otherwise, in the muscular layers.

The records of the cases show that in almost all the internal and external rings are opposite one another, forming practically one large opening. The sac can readily enough leave the canal therefore. The obstruction to its downward tendency must then arise external to the ring in one or other of the ways suggested.

A study of the peritoneal conditions existing in pro-peritoneal hernia suggests a close relationship between this form of hernia and the condition described as "bilocular hydrocele." If we suppose that the ostium abdominale becomes closed (by the normal process of "physiological agglutination") and that fluid collects in the inguinal and pro-peritoneal sacs, we should have then a hydrocele of the tunica vaginalis communicating with a serous cavity lying in the abdomen, between the peritoneum and the fascia transversalis. That is precisely the condition found in bilocular hydrocele. A reference to the recent case of Felix von Winiwarter shows that the conditions found in the removal of the sac of this form of hydrocele are the same as in pro-peritoneal hernia, save that in the former the mouth of the sac (ostium abdominale) has closed and fluid has collected in the serous cavity, and in the latter the mouth has remained open and a hernial descent has occurred.

SYMPTOMS AND SIGNS.

Pro-peritoneal Hernia: Inguinal.

With the rarest exceptions cases of pro-peritoneal hernia are first seen when symptoms of acute or sub-acute strangulation are present. A patient who for years has had a hernia, for which perhaps a truss has been worn, begins acutely to suffer from symptoms of obstruction. The hernia may be found on examination by the surgeon, taxis may be applied, and the hernia with little difficulty reduced. Symptoms of

strangulation persist and steadily increase, and operation is resorted to or the patient dies, and the condition is revealed. In some cases—a minority certainly—some swelling may be noticed after the reduction of the hernia. A "sausage-shaped swelling reaching the anterior superior spine" has been more than once reported. But in most cases no swelling is seen, and an examination of the specimens in the London museum explains that. As I have already described, the pro-peritoneal sac may pass outwards, backwards, or inwards and downwards. If outwards, a swelling or an indefinite though appreciable tumefaction may be caused; if backwards, there will be probably no swelling; and if inwards and downwards, there will certainly be none.

Strangulation of the contained omentum or bowel may occur in one of three places:—(1) At the ostium abdominale, the common orifice of the two sacs into the peritoneal cavity. (2) At the neck of the pro-peritoneal sac. (3) At the neck of the inguinal sac. If at 1, the bowel or omentum may be "reduced" from one sac to the other remaining strangled at the ostium abdominale. If at 2, there may be no signs and symptoms but those of acute obstruction, and attention may never be specially called to the inguinal region. If at 3, the case, clinically, is a strangulated bubonocoele or scrotal or femoral hernia. In some few cases, according to Breiter, it has been observed that when two sacs are clearly present, reduction of the hernial content from the outer one causes an immediate and concomitant bulging of the inner sac, and *vice versa*.

The symptoms of strangulation are, one gathers from the record of the case, neither so sudden in onset nor so swift in their increase as in the ordinary strangulated hernia. As a result operation has frequently not been resorted to till the sixth, eighth, or tenth day. In some of the cases I have noticed that "vermicular contraction" of the intestine, "coiling," and "hypertrophy" are mentioned. This would seem to indicate that some obstruction has been of long duration. The sudden stoppage of the intestine by any cause, internal strangulation or strangulation in a hernial sac, never, in my experience, causes any such condition of hypertrophy as is here referred to. A hypertrophied intestine the contraction of which can be seen through the abdominal wall, giving rise to "coiling" and "vermicular contraction," must inevitably be the result of long-standing and either intermittent or incomplete obstruction.

In pro-peritoneal hernia the ostium may be the cause of the partial or temporary obstruction. Almost all the museum specimens that I have examined are to be found, not under the heading "pro-peritoneal hernia," but under "reduction in mass." The symptoms, therefore, are in a large number of cases those of the latter condition. To this point I shall refer again.

So far as the contents of the sacs are concerned there is little to remark. In three-fourths of the cases small intestine alone is present; the omentum, large intestine, and, in one case, the cæcum, have all been noticed. Three of the cases are said to have been examples of what is commonly, though unreasonably, termed "Richter's hernia."

Cruro-pro-peritoneal hernia is much rarer than the former. Breiter records only nine cases, four on the left side, three on the right, and two undetermined. The average age of the patients is higher by several years than that of the inguinal variety. The external swelling is invariably small, and the obstruction has always been furnished by the ostium abdominale.

Diagnosis.

As can readily be understood the diagnosis of pro-peritoneal hernia before operation is sometimes a

matter of difficulty, or even impossible. In cases where a swelling, bulging, or tumefaction is noticed the diagnosis can be, and has been, accurately made. Such cases should offer no difficulty to a careful observer. The frequency of the association of testicular anomalies should make the surgeon prompt to investigate the precise nature of any hernial swelling where the testis is not in its normal position, especially on the right side. If, however, there is no inguinal swelling the symptoms are those of "reduction in mass," of acute obstruction, not as a rule of the most violent type.

Symptoms and Diagnosis of Interstitial Hernia.

In interstitial hernia the mural sac is always capable of being recognised. At one time or another the sac can be seen distended with the usual hernial contents, and no difficulty can be experienced in the recognition. The symptoms are generally inconspicuous and strangulation is infrequent.

Treatment.

Only one treatment can possibly deal effectively with pro-peritoneal and interstitial hernia—operation. The wearing of a truss is useless, and in most cases must also be a source of positive harm. The whole of both sacs should be excised, an undertaking which will involve a certain amount of division or separation of muscular and tendinous fibres. The "radical cure" can be afterwards carried out by any of the methods suited to the occasion,

REDUCTION IN MASS.

I have already remarked that my observations have led me to conclude that many cases of "reduction in mass" are in reality cases of pro-peritoneal hernia. "Reduction in mass" has been described as being the result either of a complete return of the hernia, sac, and contents, undisturbed so far as their mutual relations are concerned, within the abdomen but outside the peritoneum, or of a rupture at the neck of the sac by which the hernial contents escape from the sac into the lax subperitoneal tissue, still strangled at the neck. If the hernia be small and the patient stout the dispersion of the fluid will give an appearance of reduction, whether the fluid has escaped subcutaneously or into the subperitoneal tissue. A rupture of a vaginal hydrocele under pressure applied too vigorously by the patient has been not infrequently recorded.

The impression gathered from museum specimens alone is that the very great majority of examples of "reduction in mass" are in reality no other than cases of pro-peritoneal hernia in which the bowel has been reduced from the one sac to the other. An attempt to gauge the relative frequency of these conditions based upon museum preparations alone is necessarily unsatisfactory. Only the severer cases are there represented. Cases successfully dealt with by operation may be recorded by the surgeon; but his account, however precise, reveals a lack of that intimate acquaintance with circumstances which a careful dissection is alone capable of giving.

Reduction in mass may therefore be described as of the following varieties:—1. Reduction into a sac lying between the peritoneum and the transversalis fascia. This sac has probably received the bowel on many previous occasions. It exists in both the inguinal and femoral regions, forming the special class of hernia known as pro-peritoneal or bilocular. This sac may pass (a) inwards to the bladder, (b) backwards to the iliac fossa, (c) outwards towards the anterior superior spine. This form is probably by far the most frequent. In a very few cases—not five in all—the apparent reduction has occurred into one of the interstitial sacs, beneath or superficial to the external oblique; such a case is that of Mr. Cock (Guy's Museum, No. 1,120).

2. Reduction of the whole sac within the abdomen, but outside the peritoneum, the relations of sac and contents to one another being unaltered, and strangulation at the neck still persisting. It is probable that the loosening of the sac is of long duration, and is the result of vigorous and ill-regulated taxis. This variety is rare. It was first described by Saviard, after Le Dran, Lafaye, and Richter.

3. Rupture of the neck of the sac, and escape of the contents of the sac through the rupture into a cellular space outside the peritoneum. The rupture generally occurs at the back of the sac just below the neck. This form of reduction has been well described by Birkett. If fluid alone escapes while the bowel remains, an illusory appearance of reduction will be presented. It might be worth while to emphasise this condition as "false reduction in mass," for clinically the two conditions of "false" and "true" reduction may be precisely similar. If in "false" reduction the rupture is at the distal extremity of the sac and the discharge of fluid subcutaneous, it is impossible, of course, for bowel to escape.

As a variety of this form may be mentioned the passage of the strangled intestine through a cut made near the neck of the sac when a hernia knife has been introduced to divide the "stricture at the neck of the sac." Madyl has observed this accident. After the supposed division of the strangling band pressure is applied to the bowel, and reduction apparently occurs. The neck of the sac is however untouched, and the strangulation consequently persists. A very beautiful example of this kind is recorded by Farabœuf. This form also is rare.

A fourth form of "reduction in mass" is described and figured by Roser, and mentioned by Pick. It consists in the reduction "into the inguinal canal" of the bowel that has formerly occupied the scrotum. A wide dilatation of the canal is considered as permitting this partial reposition. I have not been able to discover a museum specimen of such a condition, nor have I found any unequivocal case in the literature of this subject, though mention of the condition is made by several of the earlier writers on hernia. Chelius considered that in herniæ of moderate or large size, when reduction was apparently complete, a small segment of gut, thick with inflammatory products and paretic, might lie inert in the canal, and undergo a later secondary strangulation.

Reduction of the strangulated contents of a hernial sac into a second underlying sac in the scrotum have been recorded by Armand, Horn, Sandyfort, and Scarpa. It is possible that these second sacs are pulled down into the scrotum by gubernacular bands in the same manner as the sac of an infantile hernia. Demmeaux has suggested that whether the sac first present in the scrotum be congenital or acquired, the press of intestine on a weak and loosely supported neck may cause a diverticulum slowly to develop. Such pouch may be in front or behind, to the inner or outer side.

If rupture of the neck of a femoral sac occurs the bowel may pass into the sub-peritoneal tissue. Callisen recorded in 1777 a case where, owing to rupture of the sac below the neck, the bowel had escaped and made for itself a lodgment between the pectineus and psoas muscles.

These conditions may be represented in tabular form thus:—

REDUCTION IN MASS.

<i>True.</i>	<i>False.</i>
1. Reduction into a pro-peritoneal sac; rarely an interstitial sac.	1. Rupture of the sac at the neck or elsewhere, with escape of fluid only.
2. Reduction of the	The hernial swelling be-

True.

whole sac, with contents, within the abdomen, outside the peritoneum, the mutual relations of sac and contents being undisturbed.

3. Rupture of the neck of the sac or its division during operation and extravasation of the hernial contents into the sub-peritoneal tissue.

False.

comes considerably smaller, but the bowel remains strangled.

2. Reduction of part of the hernial contents. A small portion remaining in the canal, paralysed and stiff with inflammatory products, undergoes a "secondary" strangulation.

The Jettsonian Lectures.

PRACTICAL OBSERVATIONS

ON

CANCER OF THE BREAST. (a)

By SIR WILLIAM M. BANKS, LL.D., F.R.C.S.

Surgeon to the Liverpool Royal Infirmary; Emeritus Professor of Anatomy in University College, Liverpool.

LECTURE I.—(Concluded).

THE PARAMOUNT IMPORTANCE OF EARLY DIAGNOSIS.

As one goes on seeing case after case with gentlemen in general practice, one gets to find out that, even with the highest standard of modern education, a great many errors are still being committed by doctors in the matter of the early diagnosis of mammary cancer. Now, seeing that in the matter of its cure we have nothing but free removal to fall back upon, the smaller the amount of disease the better the chance of cure. Early diagnosis is, therefore, of paramount importance. If this can only be steadily crammed into the minds of students and practitioners, a remarkable increase in the number of permanently successful operations will ere long result. This is the real line of improvement at the present moment, not in devising extravagant operations for cases that are past praying for. It is true that in the very early stages of a mammary cancer, a certain and positive diagnosis cannot be made, even by the most skilled and experienced surgeon. Nobody, therefore, expects that of the general practitioner. But I have found that, when the patient comes and shows her doctor a small lump in the breast, if it does not seem anything very formidable, he is unwilling to frighten her, talks vaguely about a "swollen gland," and generally is apt rather to make light of the matter. There is a phrase I know well which must have cost a great many people their lives, "If it doesn't bother you don't bother it." It is a most destructive axiom. Then the patient goes home, the lump grows and she sees it growing, but she buries her head in the sand and repeats to herself that the doctor didn't attach any importance to it, and so nothing can be going wrong. In due time she becomes terrified and repairs to the doctor. There is a distressing scene, and then they repair together to the surgeon, who says he thinks he can get the disease out, but is not sure. Now what I would implore my brethren in general practice to do is to cease regarding any lump in the breast, however small, as harmless or unworthy of the utmost attention. No man can tell what is going to become of a small lump in the breast. All strangulated herniæ are now operated upon without delay if they will not go back—so all lumps in the breast ought to be cut out, if they will not speedily disappear.

(a) Delivered before the Medical Society of London, Monday, March 5th, 1900.

As to frightening the patient there is no necessity for unnecessarily alarming her, but, even if it were so, how much better that she should get a needless fright in the beginning, than be ultimately terrified by the dreadful intimation that her doom is sealed, and that a brief period of agony is all of life that is left to her. My advice to a general practitioner would be that, when a patient comes to him with the smallest lump in the breast, he should at once send her to a surgeon. If she be a poor person he will assuredly have a surgical friend who will see her gratuitously for him. Were I a younger man I dare not say this. If an absolutely certain diagnosis cannot be made on the moment, the point is to get the patient to visit the doctor month by month to let him see what is happening to the lump. It seems hardly credible, but on several occasions I have seen a patient in consultation with her own medical man about an early mammary swelling. It has been impossible just then to give a certain opinion about it, treatment has been suggested, and a strong recommendation made that the swelling should be carefully watched. And yet, after a year or more has elapsed, they have so muddled up matters between them that the patient has been brought back with a pronounced cancer. This is a statement of fact, and not an ideal picture. We have just been considering various conditions relating to cancer, upon which have been brought to bear ingenious speculations, supported by statistical researches involving years and years of labour. All these researches are not of the faintest moment (considering the nature of the solitary method of treating cancer of the breast which we possess) compared with the value of early recognition of the disease. Every effort should be made by teachers to inculcate the doctrine of early recognition upon students for, if there is a hopeful day to come for the sufferers from cancer of the breast it will be when women have been taught by the medical profession to present themselves on the slightest symptom of anything being found wrong with the mammary gland. Too often at present they hug their distressing secret and only part with it when it cannot be concealed, and small wonder it is when one reflects that the present generation are still under the influence of the depressing tales told them by their mothers about the horrors of cancers of the breast, and the terrible and useless operations performed for its relief. I hope my medical brethren will forgive my speaking in this very forcible manner about what appears to be a very simple thing. It is a very simple thing, but, simple as it is, it is the real secret of the future of the operative surgery of cancer, and we are not getting what we ought out of it. Let me not be supposed to reproach my profession with ignorance (for I trust I can recognise the many mistakes I have made myself), but to expect omniscience from the general practitioner is absurd. I consider that the range and extent of his knowledge is astonishing, but the early diagnosis of many mammary enlargements will defy the most experienced touch. It is only by early co-operation between the medical attendant and the surgeon that the patient's chances can be saved to her.

CONSTITUTION AND HEREDITY.

One of the terrible mistakes of former days, which gave cancer the character of being even more hopeless than it is, was the idea that it was purely a constitutional disease. To remove it in one place was useless, for it would just break out in another. Now the modern scientific inquirer, whose first consideration is too often to sweep contemptuously aside all that his predecessors have excogitated, asserts that there is nothing constitutional whatever about cancer, that it is a purely local disease and that it is certainly an infective one. It seems odd why there should be

any difficulty about the question. It is a long time since Laycock first described the diathetic tendencies of the body and how they influenced all the illnesses which attacked that body on its way through life and often so modified them that they were almost unrecognisable, so changed were they from their usual types. Paget used to draw our attention very vividly to the remarkable way in which the gouty diathesis affected surgical disease. We know, nevertheless, that it does not necessarily follow that, because a man has a diathetic tendency, it need ever become obviously manifest. He may go through a long life and never show it until some *contretemps* brings it to the surface. An old friend of mine, whose male relatives to a man were all full of gout, lived to over 70 without a trace of it. He drank champagne and port most days, but he was small and thin and a passionate sportsman, so that he staved off the gout by great physical exercise. But at last one day he fell off his shooting pony and hurt his ribs. While lying in bed recovering from the injury he had a serious attack of gout in the foot. For the next two or three years of his life it never left him, and it killed him with acute cerebral trouble at the last. If in place of "gout" we were to put "cancer" into this little case there would be really no difference. But that cancer should in some way be set agoing in a particular spot of a perfectly healthy man's body by the process of infection and should then produce a constitutional state—apart from mere spreading by lymphatic channels—is with our present knowledge difficult to realise. If you were to take a fine, wholesome, clean-blooded man, the descendant of a race who had for generations been free from all morbid diathesis, and put tubercle into him you could not make it spread. It would die out locally. It requires a distempered constitution, like a sour, impoverished soil, gives the appropriate pabulum for pathological weeds, which seed and spread through it and ruin it. We know now how the tubercle gets sown. The cancer weed may yet be caught and bottled too. When we think what an absolute revolution has taken place in our views about tuberculous disease, we must not despair about cancer. It is a curious thing, however, to remember that while the North Italian peasants regarded phthisis with the greatest dread as an infectious disease, scientific medical men were the very persons who scouted the idea. Long continued experiences are worth something after all.

As to heredity, it behoves us to be very careful how much importance we are to give to this in a difficult case of diagnosis of a breast tumour, where side issues have to be taken into account. By the public, without doubt, too much value has been always attached to it. The patient consoles herself with the belief that hers cannot be a cancerous tumour because nobody in the family was ever known to have such a thing. Unfortunately, we can only put the matter in this way; while the want of history of a cancerous tendency inherited from her progenitors is no proof that the patient's disease is not cancer, the existence of it among several near relations is distinct evidence in the direction that it is so. There have been attempts made on certain abstruse developmental grounds, to overthrow the possibility of the heritability of acquired (diseased) variations, notably by the philosophic teaching of Weissmann, but nothing has come of them. A great deal of philosophic froth has been beaten up, and much learned verbiage has been poured about, but I have never seen abstract philosophy do much in disease. Our knowledge—our most useful knowledge—has been gained empirically. And so patient collectors of facts have told appalling histories of whole families who have died from cancer, and have disseminated it among their descendants, which are now so numerous

and well authenticated as to leave no doubt in the mind of any surgeon (not a philosopher) as to the existence of heredity, and what we have to do is to attach to it its appropriate value clinically, and by no means to consider that the absence of heredity is proof of non-malignancy in a tumour. It is true that as a general rule cancer in a family seems very erratic in its visitations, and appears to jump over a generation, but we may take a simple view of the question thus as explaining these irregularities. What figures seem to show is that the inherited infectivity of cancer is not strong and dies out most likely at the end of a couple of generations. In the midst of a family among whom cancer was never known a healthy man develops (catches?) cancer, and throws the gloomy pall of hereditary diathesis over his children and grandchildren. A son shows it, but his children escape, while a niece—the originator's grandchild—shows it. The rest escape because the match has not been applied to the tinder, just like my friend who escaped hereditary gout till he met with an accident towards the end of a long life, which set it ablaze in him. It is impossible to resist coming again and again to ask "What is the match?" Meantime, until a very clear answer is given to this, I see no occasion for throwing overboard what knowledge we already possess.

Dr. Boswell Park in his chapter on the "Frequency and Nature of Cancer" in the *Practitioner*, already alluded to, writes as follows: "Next with regard to the actual nature of this disease. First of all, it is possible to sweep aside, with one or two possible exceptions, everything that has been brought forward until recent years as an explanation of this disease. The old theories of irritation, of perverted nerve centres, of heredity, &c., cannot for a moment stand in view of the searching scientific methods of to-day. We have gotten as far as this at present that we know that cells act as they do in producing the disease either as the result of some external or of some internal stimulus. The exact character of this stimulus is not yet certainly demonstrated, though things point more and more towards its parasitic, i.e., its potent living influence." To the first part of this statement I entirely demur, because I am so old-fashioned as not to have got far enough to sweep aside all that experience has accumulated until I have something to put in its place. With regard to the second part it seems to involve on the part of Dr. Park what an old Scotch judge called "A plain perception of the obvious." What we all want to know is, "What is the match?" and there is no certain answer to that as yet.

Traumatism.—We are all very prone to produce some distinct reason why a disease should have come to us. That it should come spontaneously is a stigma upon the soundness of the constitution, and so we wish to find out a cause. But the natural liveliness of the female imagination makes it difficult to apportion with anything like accuracy the exact amount of credence to be placed in their statements. I must say that I have never been able to make out that milk abscess or the scars of incisions for them have ever been the starting points of cancer, and, curiously enough, although the patients have mentioned the existence of these things, I do not remember having heard them distinctly and directly attribute their growths to them. After all, if cancer ever develops in inflammatory products it is in those of a very chronic and not of an acute nature. I never heard, furthermore, any statements from the patients that pressure from corsets or that irritation of the nipple by suckling had produced their complaints. On the other hand, I have very often heard most clear and circumstantial histories narrated in which blows were asserted to have been the primal cause of the trouble. It has

been held as an argument against the effect of traumatism that men are very much more liable to blows on the breast than women, and most rarely have breast cancer. I very much doubt this. Take a number of men at fifty and an equal number of matronly, full-bosomed women of the same age, and it stands to reason that the latter will get more knocks on the mammae than the man. Moreover, they are always in the way of getting knocks from young children or from articles of furniture, such as cribs and bedposts, among which they are always working. Besides what is a man's breast after all? A little mass of fibrous tissue with some rudimentary gland stuff in it, whose small size would save it from many blows which a big, soft, vascular female breast must encounter. Moreover, it is contended that, if blows caused mammary cancer, the lesions would be multiple, but this shows how things appear differently to different people, for I do not suppose that if a woman gets an injury to her breast she gets it in the form of a series of thumps all round so as to produce multiple cancers. I have received very succinct accounts from intelligent women of blows from pieces of furniture or kicks from young children in which there was pain immediately afterwards sufficiently severe to fix the exact place in the breast in the memory. Then the pain has gone away, they have almost forgotten the circumstance until some day a lump is found at the old site of injury. Were the allegation true that the injury directs the woman's attention to a tumour which is lying concealed in her breast already, then she would discover it at once on receipt of the injury, but this is not the history of these cases. The history is that of an interval after which the lump comes painlessly. Many of the patients whose histories I have ascertained were far too intelligent to have invented the story after finding the lump. Mr. Roger Williams says that in examining the cases of 137 women, one out of four made statements as to previous traumata. I should hardly have thought so many would have done so, for, supposing we put one-half of them out of count at once as imaginary, it would leave one case in eight in which there was not improbably some truth in the patient's statement. After the way in which the vulgar but rooted belief in the infectiousness of phthisis of the Italian peasant has, in the light of modern discovery, triumphed over the contemptuous disbelief of the whole world of medicine I am not disposed to abandon all belief in the statements of women whom we will even admit to be anxious to find a cause for their malady. Constant repetition from different sources strengthens even a weak tale provided the evidence be steadily in the same direction. I have investigated these stories too often not to feel that, stripped of all exaggeration, there is a distinct element of truth in them. Remember, I do not make any attempt to assert that cancers of traumatic origin are at all frequent, but I believe in the possibility and, indeed, in the strong probability of their occurrence. I cannot see anything irreconcilable with our pathological knowledge in the idea of a blow, leaving behind it a certain limited area of chronic inflammation in which the gland epithelium should begin to grow and then burst its bounds, just as I am certain it does in chronic mastitis. Dr. Boswell Park says: "The supposed intimate relation which injury bears to cancer is of no more importance than that upon which the clinicians, and even the pathologists used to place so much stress in tuberculosis. There are still those who claim that the predisposing cause of most tuberculous joint diseases is previous injury of some character, and there are still those who look for a similar mechanical cause of cancer in virtually every case." I am not one of those who look for a

mechanical cause of cancer in virtually every case, but I venture to say that there is no practising surgeon in this country who has had much to do with joint disease who does not recognise the immense importance of wrenches, blows, and sprains in the production of the early inflammatory changes in and about joints which ultimately end in what is known as articular tuberculous disease. I was educated in exactly the opposite view, viz., that the tales which mothers told about injuries to their children's joints were all nonsense, and I was forced out of this belief by the irresistible arguments of experience.

One feels the more inclined to this view from the knowledge that acute traumatic malignancy is a well-recognised disease. Scattered throughout the medical journals are so many cases of its occurrence that no possible doubt can be entertained about its existence. In the *British Medical Journal* for 1882 are two short but very interesting papers on the subject by Messrs. Barwell and Harrison Cripps; also a third by my friend, Mr. Puzey, of Liverpool, detailing in a most interesting manner the history of a man who was struck over the sternum and in whom there was developed at the spot a sarcoma. It is true that in all the cases I have read sarcomata and not carcinomata supervened, and therefore the disease is rightly named "acute." But if injury will, so to speak, on the spot start into existence the swift growing tumour of the connective tissue, why should it not at a longer interval give rise to the slow growing tumour of glandular lining epithelium?

THE DILATATIONS AND DIVERTICULA OF THE ÆSOPHAGUS.

By JOHN KNOTT, M.A., M.D., CH B., and Dip.
Stat. Med. (Univ. Dub.); M.R.C.P.I.; M.R.I.A.; &c.

(Concluded.)

IN proceeding to notice the third or *hernial* class of œsophageal diverticula in Rokitansky's arrangement, I must take special notice of the radical views so emphatically advanced by Zenker (*Ziemssen's "Cyclopedia,"* Vol. VIII):—

"A number of the modern writers distinguish two different kinds of sac-like diverticula, which, resembling each other in their location, shape, &c., are distinguished from one another by the presence or absence of a muscular layer in their wall. They according assert that they arise in different ways, and consider those that have a muscular layer as congenital formations. But having carefully studied the literature of the subject, and having ourselves investigated four of these very preparations, we consider that this distinction has no adequate basis, but do believe that all diverticula occurring at this place must be considered as identical in anatomy and pathogenesis. Without doubt the reports of many cases by observers do assert the presence of a muscular layer in more or less precise terms. These doubts arise not only from the opposite statement of those observers who are the most reliable (Chas. Bell, Rokitansky, Ogle), and the results of our own examination of these preparations in the Museum of Pathological Anatomy at Erlangen (of which one is the most beautiful specimen of its kind), from which we find that in all these cases (except in a portion of the neck of the largest one) there is no muscular layer whatever; but above all, from the statements, partly indefinite and partly incredible, concerning the arrangement of the muscular fibres in the wall of the sac; and finally, from the result of our own examination of one of these cases, in

which the existence of a muscular layer is asserted in the most plain terms. It is that case, so interesting in every respect, reported by Fridberg (observed by Dr. Gassner in Mainz) in his careful dissertation, of which the preparation is to be found in the Museum of Pathological Anatomy at Giessen. In speaking of the large, flask-shaped diverticulum, three and a half inches long, hanging down the œsophagus, Fridberg says it is made up of 'all the layers of the œsophagus, the muscular layer is moderately developed, and the fibres run in a regular manner entirely around the sac.' Although this statement leaves nothing to be wished for in precision, yet I could not repress my doubts of its accuracy, and so had recourse to Professor Perls, with a request that I might prove this point, and he had the kindness to send me the specimen for my own examination. My examination showed, in fact, that Fridberg's statement concerning the muscular layer was totally incorrect. The mucous membrane, as in the other cases, was found to bulge outwards between the lowest separated fibres of the inferior constrictor muscle. Two of the separated fibres reached down to some extent upon the neck of the diverticulum. On all the rest of the sac not a muscular fibre can be found. Accordingly, Fridberg's argument concerning the pathogenesis, which rests upon the presence of the muscular layer, naturally falls to the ground, and the simple and natural explanation, which he opposes, is re-established. From what has been said, it is evident that this diverticulum also arises from the pharynx, and not the œsophagus, as Fridberg states.

"After this result we shall not be blamed if we believe that the few remaining cases in which a muscular layer was declared to be present are equally incapable of demonstration, as, e.g., the case pictured by Albers (Atlas, Part II., Plate xxxiii., Figs. 1 and 2), in which a 'thick layer of muscular tissue' was said to exist; but certainly it would not be suspected on examining the plate. In his interesting case, so often quoted, Kühne only says in general that the outer layer 'is made up of muscular fibres of considerable thickness coming from the œsophagus, which spread out like a web over the surface of the sac,' which certainly cannot be interpreted as meaning a continuous muscular layer. And in Worthington's case, in which 'nearly two-thirds of the sac is covered with muscular fibres from the constrictor of the pharynx,' at least a considerable portion of the sac, according to this statement, must have been free from such fibres; other cases are less capable of proof on account of even less complete statements.

"But the assumption that the muscular layer, when wanting, may have formerly been there, but has become atrophied by the enlargement of the sac (Klebs, Koenig), is not only entirely gratuitous—for the statement by Klebs, in opposition to our experience, that most of the smaller sacs present all the coats, finds no proof in the literature of the subject—but also, for the cases which we have investigated, would be entirely untenable when we consider the arrangement and origin of the fibres of the inferior constrictor through which the mucous coat protrudes."

Notwithstanding the fact that the writer of the above paragraphs has evidently given the most careful—even enthusiastic—attention to this seldom-studied section of pathology, I cannot help expressing the opinion that his view is too exclusive. The fact of the absence or wide dispersion of the muscular fibres in the wall of a sac of long standing, when even of but moderate size, is no proof that they did not exist at the time of the original expansion. And I will even go so far as to hold it to be a physical impossibility for a local bulging of the mucous membrane of the normal œsophageal—or pharyngo-œsophageal—

wall to take place without carrying muscular fibres in its circumference. The only cases in which such an accident could possibly occur would be those in which there exists a local deficiency in the muscular fibres, which would mean a congenital predisposition—if not an actual congenital preformation—to the reality of which Zenker so very strongly objects. There is one other point which, in my opinion, strongly militates against the exclusive view taken by Zenker. Referring to the frequency of regurgitation of food, he observes that, "The ingesta which have fallen into the diverticulum may remain there one or many hours (perhaps even for days—case of Collomb), when apparently involuntarily in part (probably by compression of the sac laterally by the contraction of the muscles of the neck), and partly by pressure with the hand upon the neck, they are again brought up into the mouth, sometimes entirely unchanged and sometimes only softened and mixed with mucus. Then they are either ejected from the mouth, or the patient attempts to swallow them again, so that in many cases there is actual rumination. This symptom is most characteristic, although, as we saw, it occurs also in diffuse dilatation." [The italics are mine.] The views of an enthusiast, if not gifted with an exceptional quantity of mental ballast, are very likely to run into a one-sided advocacy; and venture to express the opinion that the above quotation offers an example of this rule. The "probably" begs the question of the source of the pressure exerted upon the contents of the sac; and I believe that all discriminating readers will agree with me that it is most unlikely that a special form of contraction of the muscles would be unaccountably brought into play at such long and irregular intervals in a case where there existed a continuous source of uneasiness. The influence of the pressure of the hand upon the neck is, of course, unmistakable; but it is unlikely to be employed till the sac has attained so considerable a size as to form an evident local bulging. When it does the discomfort caused by its pressure is sure to lead to manipulation, which is also sure to be repeated after each meal; or, as in some cases, after each act of deglutition. The result, simply or in combination, of these two factors of compression would not, I submit, give the regularly-recurring habit of rumination which existed in some of the recorded cases; and still hold that the "apparently-involuntarily-in-part" regurgitations, of which the existence is unquestionable, can only have been due to the action of the muscular fibres in the wall of the diverticulum itself.

Zenker also expresses the opinion that the lodgment of a foreign body is "perhaps the most frequent method of their origin." The most remarkable case on record of such (apparent) origin is, so far as I know, that of Ludlow, which I have already dealt with at length. Other cases referred to by Zenker are those of Dendy, in which an eight-day lodgment of a peppercorn formed the first item in the history; of Kühne, in which the corresponding agent was a chicken-bone; of Klose and Paul, in which the corresponding offender was a fish-bone.

An extremely interesting and suggestive case bearing upon this method of causation has been recorded by Mondière (Arch. Gen. de Méd., 1890). I must mention that he accepts Ludlow's view of the *modus operandi* of the foreign body in the case above quoted; and, of course, in other corresponding cases. He then proceeds, with evident intellectual unction, to give the history of a case: "*dans lequel la nature fut pour ainsi dire prise sur le fait*":—

A peasant, æt. 20, of robust constitution, swallowed during sleep a stone with which he had been amusing himself for some little time before by rolling it in his mouth. After awaking he felt severe pain in the

chest, together with complete inability to swallow. The symptoms progressed with increasing severity, and he died nine days after the occurrence of the accident, and, on examination of the body, the œsophagus, stomach, and parts of the intestines, were found in a state of gangrene. The stone, "*était en quelque sorte chatonnée*," in the lower part of the œsophagus, where it had formed a sac on the right side; this sac was corroded by the suppuration, so that a portion of the stone lay bare in the cavity of the thorax, beside the trachea.

Now, the above case, although brought forward with very evident eagerness by the distinguished French pathologist, as the brightest available illustration of the mode of formation of sacculated diverticula of the œsophagus, does not, in the opinion of the present writer, by any means lend—even a shadow of—support to his view of their development. I can quite understand the pressure of so hard and irritating a body on the walls of the gullet leading to violent inflammation, ending in sloughing and perforation, with supervention of complications necessarily ending in a fatal issue. But with regard to the formation of diverticula, I have no hesitation in asserting that the above case, if it proves anything, proves that such a foreign body could not lead to the formation of a sac, as the want of adaptability of the œsophageal wall in that instance was absolutely demonstrated. And if that stone had met with a (congenitally) weak yielding spot in the wall of the tube, it is just possible that its pressure might have led to the gradual development of a sac of some size. But it is only in the case where the pre-existence of, at least, a slight bulging could have afforded accommodation to the obtrusive foreign body—and without complete interruption of the act of swallowing—that the presence of such an agent could possibly have led to the result in question. The tolerance of a sac, when fully developed, for the presence of foreign bodies was shown in Förster's case, in which several pieces of buck-shot were found in the fundus, which had become smooth by mutual attrition, and in Zenker's own case, in which he found a little piece of slate "somewhat larger than a kreuzer." In the Veit-Berg case, a piece of coarse corn was present; and in the famous case of Ludlow, to which I have so often referred, the sac contained a large quantity of quicksilver which the patient had been made to swallow fourteen days before his death.

As illustrations of the other forms of mechanical injury which may lead to the formation of a pouch in the gullet or its vicinity, I may again refer to Gasner's case (reported by Fridberg), in which the accident to which a pharyngeal diverticulum could undoubtedly be traced was a fall from a horse; to Waldenburg's case, in which the origin was referred to a quarrel in which the patient, a female, was throttled by her opponent; and to the cases mentioned by Kühne and Buckling in which the primary cause was believed to be the pressure of tight clothing around the neck. These cases were, however, all pharyngeal.

Zenker, who is so emphatically sceptical with regard to the congenital origin of the majority of these pouches, refers to eight cases in which the symptoms commenced after the age of forty. He is disposed to regard ossification of the cricoid cartilage as the principal factor in such instances; the normal resistance thus developed in front throwing so much pressure on the posterior wall of the tube. Sir Charles Bell referred the origin of some of the pouches which form at the junction of the pharynx and œsophagus to the obstruction produced by spasmodic contraction of the upper part of the muscular wall of the latter; the same idea was also entertained by Monro. But although recurrent spasm in this position—so-called *œsophagismus*—is a well-

known source of trouble, especially in female patients of "neurotic" temperament, it is more than doubtful whether such functional derangement is ever, of itself, the cause of so pronounced organic change.

Local paralysis of the muscular walls of the tube is a recognisable cause which may lead to the formation of a diverticulum. The same may be said of ulceration, either simple or specific, which, by weakening of the parietes at any point, would necessitate their yielding to the pressure of the ingesta during deglutition. I have myself under observation at present a case in which I believe that a small diverticulum has formed; and from a cause which I do not recollect to have found recorded or suggested elsewhere. A lady, whom I treated for œsophagismus some eight years ago, went to reside in a London suburb, where the trouble required frequent use of the œsophageal bougie. On coming to Dublin a few weeks ago she consulted me again about her dysphagia, which I naturally thought would turn out as before to be of nervous origin. The hitching of the bougie on some occasions, with its free passage at other times, leaves no doubt on my mind that a pouch has developed. She states that her London practitioner had often to use a good deal of force to pass the instrument.

The existence and genesis of "traction-diverticula" of the œsophageal wall has been made the subject of very careful study by Zenker. The first description of this peculiar lesion was furnished by Rokitanaky. His original account was based on a single case. This appeared in 1840; but, till the publication of Zenker's observations, the subject does not appear to have received much attention.

"The starting-point is an inflammatory swelling of the parts immediately adjoining the œsophagus, which leads to a firm adhesion between this inflamed region and a limited portion of the wall of the œsophagus. If cicatricial induration and contraction follow in these inflamed regions, since they are also adherent to less yielding structures (particularly the wall of a bronchus), they must draw that portion of the œsophageal wall outward. This method of origin in the great portion of cases is so evident from the anatomical appearances that in the presence of such preparations there can be no dispute about it. Experience tells us that it is disease of the tracheal and bronchial glands, especially those at the bifurcation, which is the most frequent cause of such inflammation; and it is the dense accumulation of these glands at the bifurcation which makes the corresponding portion of the œsophagus the seat of election for the formation of these diverticula." The remote cause of the condition is, in the majority of cases, not discoverable. Zenker looks upon tuberculosis and chalicosis as the most frequent sources.

This distinguished pathologist had seen and investigated more than sixty such cases at the time of the publication of his observations in Ziemssen's "Encyclopædia." He has there given sufficient evidence of the great danger of the existence of these—usually unsuspected—pouches. "Their shape, with rare exceptions, is that of a narrow or somewhat wider funnel of only moderate depth. Most frequently we found them from two to eight millimetres deep; yet in a few cases they attain a depth of nine to twelve millimetres. Larger diverticula than this certainly are very rare exceptions." In many of these cases the mucous coat alone forms the sac—protruding between the muscular layers. When a foreign body happens to lodge in one of these little sacs, or some source of irritation leads to inflammation, there is great danger of perforation, which is extremely likely to lead to a fatal issue. The opening is often into a bronchus; it may also be into a pleural cavity or into the pericardium. Cases of perforation of the aorta and of the pulmo-

nary artery have also been observed—followed, of course, by immediate death.

Down to the happy era of the researches and results of Lister and of Pasteur, the condition of oesophageal dilatation was one of the most distressingly hopeless of the ills to which suffering humanity is heir. The colossal strides made by advancing surgery since the perfecting of its aseptic methods have, however, achieved successes even in this, which had previously been one of the most unmanageable of all human ailment. Von Bergmann, after extirpation of the diverticulum, did not attempt to secure healing by first intention. Billroth left in an oesophageal tube through which he fed the patient for some days. Kocher preferred rectal alimentation to using any means that might cause disturbance of the process of union in the wall of the gullet. But Dr. C. Hoffmann has recently recommended a more rational line of procedure than any of these. In the *Deutsch. Med. Woch.*, August 3, 1899, he urges the advantages of his method, of which he reports two successful cases: Gastrostomy should be performed some time before excision of the oesophageal sac is attempted, because (1) the patient can be fed up into good condition so as to enable him to bear the second operation with better hope of success; (2) the oesophagus obtains rest, and any inflammation existing in the wall of the sac has time to subside; (3) the sac, if large, can be washed out, and all traces of decomposing food removed. The second and third of these are very important items, aiding primary reunion of the oesophageal wall after operation. I look upon this as the most scientific and the most hopeful method of procedure in dealing with all *Dilatations and Diverticula of the Oesophagus*. I look upon this as the most hopeful method of procedure in dealing with all *Dilatations and Diverticula of the Oesophagus*.

Clinical Records.

OVARIAN TUMOUR OF AN UNUSUAL CHARACTER. (a)

Under the care of Dr. T. JASON WOOD.

The patient was a married woman, æt. 48, admitted July 29th, 1891, to hospital with a six months' history of abdominal pain and swelling. The pain had become worse since May. On admission, patient, looking very ill, was pale and emaciated, complained much of pain and nausea, has vomited once. The abdomen is uniformly distended by a tense cyst, which reaches 2 ins. above the umbilicus. There is much tenderness on pressure. Flanks resonant to percussion. On vaginal examination the uterus was found to be high up and fixed. Temperature 100.5 degs., pulse 114.

On August 4th, patient under ether, the abdomen was opened below the umbilicus. The peritoneum was greatly thickened, and the cyst universally adherent. It was found to be multilocular in character, and some of the loculi contained fetid green pus. During separation of the cyst the wall gave way in places, and allowed some of the pus to escape into the peritoneal cavity. When all the adhesions had been separated, it was found to be possible to remove the cyst, there being no trace of a pedicle. The small intestines were confined to the upper part of the abdomen by adhesions, so that the cavity occupied by the tumour remained. It was washed out with hot water and loosely packed with alembroth gauze. The end of the gauze was brought out of the wound, which was closed, and a cotton-wool dressing applied. The ovaries could not be recognised owing to the great inflammatory thickening of the peritoneum. The gauze was removed after forty-eight hours, and a tube substituted. The patient made a good recovery. Discharged September 16th. On examination of the

cyst, such of the loculi that did not contain pus contained a clear straw-coloured fluid. Microscopic examination showed the wall to be composed of fibrous material lined with cubical epithelium. The cells were rather smaller than are usually seen in multilocular cystomata.

Dr. Wood suggested that the absence of a pedicle was to be accounted for by the ovary becoming detached from its usual connections, and then undergoing cystic change.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, MARCH 9TH, 1900.

SIR R. DOUGLAS POWELL, Bart., President, in the Chair

DR. RICHARD CATON on the

PREVENTION OF VALVULAR DISEASE IN ACUTE RHEUMATISM.

Feeling strongly the great importance of the sequelæ which frequently follow valvulitis in attacks of acute rheumatism, the author began nineteen years ago to try various measures of prevention. Fifteen years since he decided upon a definite method, which has been followed ever since. The clinical material to which this method has been applied consisted in nearly five hundred cases of acute rheumatism. These were treated in the ordinary manner by salicylates, cholagogues, and a light diet, the whole body excepting the head was clothed in flannel, and the patient kept in bed for some weeks; any lingering pains were dissipated by small blisters locally. The proportion of cases of valvulitis was under 20 per cent. The following signs were considered to indicate affection of the valve; *assourdissement*, going on to the development of a bruit, usually mitral, mostly systolic, but sometimes presystolic, heard in the axilla, followed by accentuation of the second pulmonary sound; more rarely a diastolic bruit at the aortic cartilage. Treatment consisted in the three following measures:—(1) Absolute rest in bed for several weeks. (2) The application of a series of blisters, in size somewhat less than a florin, one at a time, in the course of the 1st, 2nd, 3rd, and 4th dorsal nerves; after each blister a small poultice is applied. (3) Sodium or potassium iodide in eight or ten grain dose is given thrice daily; in some cases small doses of mercury. The object of the rest in bed is of course to protect as far as possible the softened and weakened valve cusps from pressure. The object of the blisters is to stimulate the trophic nerves of the heart through the sensory filaments of its related skin area, and so as to hasten repair and absorption, just as the reparative process in a joint is unquestionably stimulated by blistering the adjacent skin. The purpose of the iodides or mercury is to help absorption of the, at first, imperfectly organised inflammatory products in the cusps and endocardium. The author believes this treatment only to be of use if commenced early, say within the first two or three weeks. In long-standing cases it is absolutely useless. Carefully setting aside all cases of slight transitory bruit, all cases of hæmic origin and all that seem due merely to a weakened and dilated ventricle, eighty-five cases remained for treatment. These were divisible into two groups: 1st, those which on admission into hospital had a bruit, probably, but not certainly of recent origin. They numbered fifty-four; of these thirty-four left hospital with hearts apparently sound, while twenty were believed to have valvular disease. 2nd, those in which the bruit and other signs of valvular disease came on in hospital, or in which the onset had been recently observed by the practitioner who sent in the case. They numbered 31; of these 27 left hospital with an apparently sound heart, three with valvular disease and one remains under treatment. As far as possible the apparently cured cases have been kept under observation for months or years. One unsatisfactory point should be noted; if in a case apparently cured, rheumatism occur,

(a) Read before the Bradford Medico-Churgical Society, February 20th, 1900.

at an early date, the endocarditis generally recurs also, and, though sometimes it is again removed by treatment, more frequently it persists. The author gave a brief summary of 85 cases and read details of three. The author's experience of rheumatic endocarditis causes him to insist strongly on the two following principles. First, that every case of acute rheumatism should be regarded not merely and essentially as *rheumatism*, which is in itself comparatively unimportant, but, first and before everything else, as a case of *impending peril to the heart*, endangering the whole future life of the patient. Whenever the heart is sound at the outset the practitioner should examine it daily. Secondly, in all forms of acute endocarditis, there is a brief stage during which, if treatment is begun promptly, the disease is usually curable. In adults this stage probably only lasts two or three weeks; in children it is longer. In children, and to a less extent in adults, by persistent rest alone some cases recover. In the author's opinion the proportion of recoveries is larger if the three measures above described are adopted and persevered in for at least six weeks. The *bruit* usually becomes soft, and after being for a time variable, finally vanishes. After disappearance of the *bruit* and other symptoms, avoidance of all active exertion is desirable for at least two months further.

The PRESIDENT observed that there could be no difference of opinion as to the importance of perfect and prolonged rest. Some difference might possibly obtain in regard to the use of the iodides, and also in regard to blisters which, in young or nervous persons, might interfere with physiological rest. He did not think that any case of rheumatic endocarditis could be described as "unsuitable" for treatment on the lines laid down by the author. He insisted on the good results of careful and prolonged treatment of endocarditis, and upon the disastrous consequences of leaving endocarditis to take care of itself when the rheumatic disease had apparently subsided.

Dr. BURNEY YEO recalled that upwards of twenty years ago he had called attention to the value of the iodides during convalescence from rheumatic endocarditis ("Manual of Medical Treatment," page 308). Under its influence he has seen the physical signs disappear. Blistering over the præcordia was an old method of treatment. Dr. Harkin, of Belfast, was in the practice of putting a very large blister over the præcordia, and Dr. Whittia was loud in his praise of the effects. He remarked that much harm was done in these cases of rheumatic endocarditis by the routine use of digitalis, which certainly did not promote functional rest.

Dr. F. DE HAVILLAND HALL said that as one of the survivors of the præsalicylate days he was able to add his testimony to the value of blisters in the treatment of pericarditis as well as of endocarditis. He always began, in the case of hospital patients, by the administration of three grains of calomel with a grain of opium, repeating it from time to time if the bowels were constipated or if there was much pain. He referred to the frequency with which valvular disease in children was overlooked, and he urged that if more care were taken heart disease would probably be less frequently the result of the disease than was actually the case. The salicylate treatment had incontestably done a vast deal to lessen the misery of the disease, but he did not think it had materially lessened the stay in hospital; in fact, by relieving the pain so promptly it encouraged the patient in the desire to go out early. He commented on the short periods during which some of the author's patients had remained in hospital, in some instances only four weeks. He remarked that many patients who left the hospital apparently quite well afterwards developed signs of heart disease, so that a man who had had a recent attack of rheumatic fever, even if exempt from signs of valve lesions, could not be regarded as a good subject from a life assurance point of view. He mentioned that the late Dr. Sturges had described the condition of the heart in these cases as "pancarditis," which he thought well described the condition. He called attention to the anæmiating influence of the disease on the body generally, and said that during the last ten days or so of the patient's stay in hospital he always gave them

iron, arsenic, and, perhaps, strychnine. He agreed in deprecating the indiscriminate and too frequent use of digitalis in the early cases. In conclusion, he remarked that if iron were given too soon it tended to bring about a recrudescence of the arthritic pain.

Dr. MORISON recalled that sixty years ago the late Dr. Hope had laid down lines of treatment, except in regard to the salicylates, identical with those formulated by the author. The old physicians had a great horror of applying blisters in pyrexial conditions, but he added that personally he had never seen any inconvenience result from that practice. He then discussed the various explanations of the way in which blisters acted.

Dr. MACLAGAN remarked that rheumatism of the joints quickly subsided under treatment whereas rheumatism of the heart was very slowly recovered from, probably because it was easy to afford complete rest to the joints and much less easy to the heart. He attached primordial importance to rest as a factor of treatment, and with this and suitable medicinal treatment he thought that many cases would recover perfectly. Formerly when the disease ran a long pyrexial course the damage could not be recovered from, but under the salicylate treatment that no longer obtained. He observed that in acute rheumatism the heart was usually affected within the first week and he commented on some of the author's cases in which this competition was not noticed until the third week. He admitted that blisters afforded relief, but they were not applicable in the cases of children or nervous women. He pointed out that in regard to the heart that it was not the endocardium that was affected but the fibrous structure of the valves, and this gave rise to no physical signs, consequently it could not be recognised. It was not until nodules were thrown out that it became perceptible. It followed that the first stage passed unnoticed. He pointed out that the growth of these nodules could not be the result of friction but was the consequence of the inflammation of the fibrous elements of the valves.

A FELLOW observed that the practice of blistering the joints required to be carefully considered before arriving at any conclusion. The disease was possibly one of septic origin, and effusion into the joints removed much of the poison from the system, and its occurrence was associated with much relief to the pain. That blisters gave much relief to the joint pain they all knew, but whether they were good in regard to the general condition was another question.

Dr. POYNTON discussed the pathological aspects of the question, and mentioned that in a recent series of 24 cases of acute rheumatism admitted to hospital, two of them had endocarditis on admission, and of these two one went out well and all the others left well. He insisted on the changes that took place in the heart muscle in this connection, and he referred to the results of his examination of the heart muscle in six cases of acute rheumatism, in five of which there was marked fatty degeneration. In chronic cases he had found fibrotic changes spreading to the vessels, with foci of cellular infiltration between the muscle fibres. He pointed out that these changes could not be due to the valvular disease nor to pericardial inflammation. The fatty change was not due either to interference with the coronary circulation, in proof of which he instanced a case of syphilis of the heart causing almost complete obstruction of the coronary arteries in which no fatty change was found. He also mentioned other cases in which the changes were obviously of long standing. In a case of very acute chorea which proved fatal the valvular disease was slight, but there were numerous micro-organisms with pronounced fatty change. He suggested that just as the toxin of diphtheria acted directly on the heart so the poison of rheumatism had a direct effect on the heart muscle. In considering the treatment they must take into account not only the valvular disease, but this undoubted action of the disease itself.

Dr. EWART asked the author whether he opened the blisters? With regard to the action of iodide of potassium he pointed out that this drug did not, as was generally believed, tend to coagulate the blood, but, on the contrary, kept it fluid, and in a disease such as endo-

carditis, in which the lining membrane of the heart was diseased, he urged that this effect was likely to be beneficial.

Dr. DAVIES referred to a series of twenty-four cases published by his father in the "London Hospital Reports" for 1864, who all went out without any cardiac disease. His father's treatment was exclusively by blistering, and if he had to choose a treatment for himself he would prefer blistering to the salicylates.

Dr. LONGHURST protested against the adoption of any particular method of treatment for all cases urging that each case required to be considered by itself, the underlying constitutional condition—syphilitic, tuberculous, &c.—being borne in mind.

Dr. CHAPMAN suggested that the iodide acted by lessening the blood pressure, thus reducing the work to be done by the heart.

Dr. HALE WHITE observed that it was often very difficult to say when the valvular disease was recent or otherwise, and if the author's tables were looked at with this fact in mind the results would be seriously modified.

Dr. SEYMOUR TAYLOR agreed that great relief of pain was afforded by blisters, but he thought it was a very round-about way of getting at the endocardium to blister outside the chest. To be efficacious the blister ought to be applied at the back of the neck where the cords containing fibres for the heart came off. Rest was the most important element of any treatment intended to prevent endocardial deformities. Patients ought never to be allowed out of bed under six weeks, and then iodide of potassium might come in useful. He asked to which factor of his threefold treatment the author attached most importance. He insisted on the value of the salicylate treatment provided the drug were given in suitable doses.

Dr. A. GARROD thought that as a rule very little was done in hospital by way of treatment in recent cases of endocarditis, and he agreed that if it were possible to do anything it ought to be done. He concurred in the great value of rest for weeks and even months, and he held that a patient who had shown signs of endocarditis ought to be advised if possible to remain on one level for at least six months. He suggested that it would be very interesting if the author could give them parallel statistics of cases treated at the same hospital on different lines. He was not convinced that the author's results on the whole were better than those which would be obtained by rest alone carried out to the very end. So long as three factors were included in the treatment it was impossible to say to which of them the results were principally due. He pointed out that an attack of rheumatic fever did not end with the patient's leaving the hospital, for the patient was exposed to many relapses of the joint trouble, and probably the same held good of the endocardial lesion.

Dr. CATON, in reply, said that he gave as much salicylate as the patient could bear, fifteen to twenty grains every three or four hours, reducing the dose if necessary to ten grains every hour or two. He continued that treatment for a considerable time after the pain and fever had disappeared. He contrasted the course of an attack of rheumatic fever of to-day with that of pre-salicylate days. In the days before the introduction of the salicylates he used to treat many cases exclusively by blistering with better results than were obtained by the then prevalent alkaline treatment, and he believed that the proportion of cardiac disease was less. He observed that a blister ought never to be larger than a florin, and such blisters could be applied to women and children without inconvenience. He applied a small poultice afterwards, and the serum escaped. He used the same treatment for pericarditis, but he thought this lesion tended more to get well of itself. He admitted that in his earlier cases he was not impressed with the importance of rest as he was at present, so that some of the patients certainly left hospital earlier than they ought to have done. He pointed out that he did not apply the blister over the heart but over the upper left chest, over the region, in fact, where the cardiac nerves were given off. Rest alone, or even with the salicylates, had not given him good results.

HARVEIAN SOCIETY OF LONDON.

MEETING HELD THURSDAY, MARCH 1st, 1900.

Mr. W. H. LAMB, M.B., President, in the Chair.

Dr. RISIEN RUSSELL made a communication on the

CLINICAL EVIDENCE UPON WHICH WE RELY FOR THE LOCALISATION OF CEREBELLAR DISEASE,

and illustrated his subject by lantern slides. While dealing with the question from a clinical standpoint, frequent reference was made to the evidence derived from experimental physiology, and he showed how this is to be utilised in clinical work. In referring to the attitude which characterises a unilateral lesion of the cerebellum (inclination of the head to the affected side so that the ear and shoulder are approximated, and rotation so that the chin points to the opposite side) he said that this sign cannot be too implicitly relied on in clinical investigations, and quoted a case in which a tumour was situated in the opposite lateral lobe of the cerebellum to that indicated by the patient's attitude. Moreover, he has met with cases of cerebral tumour in which the same sign has been present, in one of which the growth was situated too far forward to allow of the possibility of direct pressure on the superior peduncle of the cerebellum. Rotation is so rarely met with clinically, and the direction of reeling is so inconstant that these phenomena are of little value in localisation; but ataxy of the limbs is commonly more marked on the affected side in unilateral lesions of the cerebellum. Motor paresis is sometimes met with in the limbs on the same side as the affection of the cerebellum, and is an indication of cerebellar insufficiency, for such theories as have been advanced to account for it by pressure on the pyramidal fibres cannot account for the fact that the phenomenon has resulted from softening of the cerebellum consequent on vascular occlusion. Convulsions do not belong to the symptomatology of cerebellar lesions, except as consequences of secondary disturbance of other parts of the central nervous system, unless Dr. Hughlings Jackson's view be accepted that peculiar tetanic-like seizures which occur in certain cases of tumour of the middle lobe are of cerebellar origin. Rigidity follows experimental ablation, but when present as a result of disease of the cerebellum usually indicates secondary interference with the pons, for with the cerebellum alone affected there is more likely to be hypotonia of the muscles. The state of the knee-jerks affords little aid in localisation, for while there may be increased activity on the affected side as after experimental ablation, there may, on the other hand, be diminution on the side, or there may be great variability, or both may be abolished. Valuable information as to the side affected is derived from evidence of implication of the fifth, seventh and eighth cranial nerves, and, in a few cases, from the twelfth; but even this evidence cannot be relied on as infallible.

Dr. LEONARD GUTHRIE cited cases illustrating the difficulty in localising cerebellar lesions, and even in deciding whether they existed at all. A boy, æt. 5½, had typical "cerebellar" gait, loss of knee-jerks, ataxy, and "intentional" tremors of upper extremities, left-sided facial paralysis, headache, and increasing drowsiness and languor for nearly three months. He then made a rapid recovery, and three years later remained in perfect health. Here symptoms of cerebellar disease were possibly due to polyneuritis. Another boy, æt. 7, had cerebellar gait leading to ataxia, weakness, and ataxy of right arm, loss of left knee-jerk and exaggeration of right, double optic neuritis, vomiting, and frequent headache, referred to the left frontal region. The symptoms pointed to right-sided cerebellar lesion, but a cyst of the middle lobe of the cerebellum was discovered. This case showed that the "crossed cerebellar" headache was not so valuable a localising sign as it had been held to be. A lad, æt. 18, now under observation, had "intention tremors," ataxy and weakness of right arm, slight spasticity of right leg, with exaggerated knee-jerk and ankle clonus, with normal plantar reflex, shambling, awkward gait, double

optic neuritis; but neither headache nor vomiting. The symptoms apart from the optic neuritis resembled those produced by destruction of the right cerebellar hemisphere, yet they were not conclusive evidence of such a lesion. Finally, he mentioned a case in which symptoms pointing strongly to tumour of the right cerebellum, proved to be due to tumour of the corpora quadrigemina.

Dr. H. A. CALEY remarked on the clinical importance in relation to localisation, of the association in some cases of unilateral paresis with a lesion of the cerebellar hemisphere on the same side. To overlook this point might lead to serious error in differentiating between cerebellar and cerebral lesions.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.

A CLINICAL MEETING WAS HELD AT THE WEST LONDON HOSPITAL ON FRIDAY, MARCH 2ND.

Mr. L. A. BIDWELL, Vice-President, in the Chair.

Dr. CAMPBELL POPE showed a case of brachycardia in a child. The girl, *et.* 9, had had pleuritic effusion on the left side, following whooping-cough two years previously. She had also been run over and kicked in the head by a horse. The usual pulse rate was 33. Dr. Campbell Pope showed a man who had been operated on by Mr. Marmaduke Shield for abscess of the spleen.

The cases were discussed by Dr. Seymour Taylor, Mr. Rickard Lloyd, and the Vice-President. Dr. Campbell Pope briefly replied.

Dr. SEYMOUR TAYLOR showed a case of palsy of the sixth, seventh, and eighth cranial nerves.

Remarks were made by Dr. S. D. Clippingdale, Mr. G. Pernet, Dr. Campbell Pope, and Mr. R. Lake. Dr. Seymour Taylor replied.

Dr. PHINEAS ABRAHAM showed two cases of skin disease: (1) A case of pemphigus; (2) a case of dermatographia. The latter an extremely well marked instance of a rare affection. Some words which had been written on the skin of the chest in the afternoon were quite distinct at a late hour in the evening, and, indeed, still stood out prominently from the surrounding skin.

The Vice-President made some interesting remarks on the condition and Dr. Abraham replied.

Mr. H. J. PATERSON showed a case of psoriasis. There was great difficulty in the diagnosis between simple and syphilitic psoriasis. Although the eruption had the character of a syphilitic rash, and although it had not the appearance and distribution on which we relied in making a diagnosis of simple psoriasis, yet the general opinion was that the case was one of simple psoriasis.

Remarks were made by Dr. P. Abraham, Mr. G. Pernet, and Dr. T. H. Dickson.

The VICE-PRESIDENT showed two cases of pyloroplasty.

Dr. A. H. W. CLEWOW showed a case of excision of the pylorus; the operation had been performed by Mr. C. B. KEETLEY with excellent result.

Mr. MATTHEWS DUNCAN for Dr. F. G. D. DREWITT showed a case of aneurysm of the aorta in a woman, *et.* 41.

Mr. BASSANO showed a man suffering from great deformity of the chest on the left side, due to congenital absence of ribs.

BRADFORD MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD TUESDAY, FEBRUARY 20TH, 1900.

The President, Mr. HORROCKS, in the Chair.

Dr. BRONNER showed a series of specimens, macroscopical and microscopical, illustrating growths of the nose.

Dr. CROWLEY showed specimens—(1) cancer of uterus, with secondary deposit in lungs; (2) a thrombus of the pulmonary artery firmly adherent and evidently of old standing; (3) perforating tuberculous ulcer of the small

intestine; (4) the brain of a microcephalic idiot. The child was three years old, weighed 14½ lbs., and the brain weighed 11 ozs.

Mr. ALTHORP showed specimen of a very extensive tumour of the thyroid gland occurring in a child seven years old. The patient had been apparently in good health till about three months before admission to hospital, when it was said to have developed whooping-cough, and soon after this the mother noticed an enlargement of the neck. The child was found after admission to suffer from attacks of severe inspiratory dyspnoea, which were at first relieved by medicine (belladonna), but this drug soon lost its effect, and failed to control its paroxysms. The thyroid body was seen to be greatly enlarged laterally, and the isthmus much thickened. The isthmus of the thyroid was exposed and divided between two ligatures. This gave great relief, and for a fortnight the child had no attack of dyspnoea. At the end of this time, however, it had another paroxysm, which proved fatal. On post-mortem examination there was found to be a large tumour of the thyroid body, which spread downwards into the mediastinum, completely surrounding the trachea and invading the wall on the right auricle. The growth was a lympho-sarcoma.

Dr. RABAGLIATI showed a portion of the ramus of the lower jaw, which had been removed by operation. The patient had a cystic swelling of the jaw which had been repeatedly tapped without relief and was supposed to be sarcomatous. The portion of the jaw was consequently removed.

Mr. HORROCKS showed a right tubal pregnancy of about six weeks' duration, which had ruptured into the broad ligament and was removed by abdominal section. It was taken from a woman, *et.* 35, who had had no child for twelve years, but during that time had two abortions. She had apparently a third abortion at the beginning of the present illness, and discharged a thick-walled cyst from the uterus. The discharge of blood continued for some time. On examination there was found a rounded swelling closely attached to the uterus, and this when removed was found to be the specimen shown.

Dr. METCALFE showed two sarcomatous tumours which had been removed from the popliteal region at the site of an old bullet wound. The patient had been wounded in battle eighteen years before. The wound healed, and nothing was noticed for nine years, when a swelling formed in the scar and was excised and said to be a fibroma. No further trouble was experienced till two years ago, when he twisted his lower limb violently and a good deal of blood was effused beneath the skin at the site of the old injury. This never cleared up and eventually the tumours shown developed and were removed by operation. They were found to be sarcomata on microscopic examination. One was solid, the other cystic.

Dr. T. JASON WOOD read notes of an unusual case of ovarian tumour which will be found under "Clinical Records."

Mr. J. BASIL HALL read a paper on gastrotomy, with an account of two cases, and made remarks on palliative operations in general, particularly colotomy. After reviewing the history of the operation of gastrotomy, the methods of performance as introduced by Albert and Witzel were described. The former being advocated when it was possible to bring the stomach readily to the surface, and the latter when the stomach was contracted. Mr. Hall strongly advocated the performance of gastrotomy in cases of malignant disease of the *œsophagus*, and urged that the operation be not delayed after the power of swallowing solid food was gone.

Drs. HORROCKS, ALTHORP, and WOOD made remarks.

Dr. LODGE advocated the use of resting tubes in *œsophageal* cancer.

Dr. HALL replied.

THE *Lancet* postcard *plébiscite* of medical practitioners on the subject of the Midwives Bill gives the proportion of five to one against it.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, March 10th, 1900.

OBESITY.

At the meeting of the Académie de Médecine, M. Deboue presented a man of fifty-five whom he had treated successfully for obesity. On entering the hospital the patient weighed 234 pounds; at present, that was to say after a year's treatment, he weighed only 180 pounds. The mother and brother of the man were also of large corpulence; he was consequently predisposed to his malady. It was at the age of twenty-five that he commenced to grow fat and that tendency was encouraged by the sedentary existence and the alcoholic habits of the patient. To that obesity were added two maladies which frequently accompanied it, gravel and gout. It was necessary to reduce his weight as he had become entirely impotent. What curative method should be employed? One of three. The first consisted in the administration of preparations of the thyroid gland; but that medication was dangerous, especially where it was necessary to be continued for a long time; besides, the results of it were purely temporary. For both of those reasons he did not wish to have recourse to it in treating the patient. The second method consisted in forcing the patient to take active exercise so as to provoke a waste of tissue, but the man could not leave his bed. The third method, that of insufficiently nourishing the patient so as to oblige him to consume his fat was the only one applicable to his condition.

During the first month of treatment he was put on two quarts of milk a day, the second one and a half, and the third month one quart only. He lost by this way 27 pounds the first two months, and four pounds the third month. During the four following months the patient took less than a quart of milk a day, and then only weighed 190 pounds, and, finally, his weight fell to 180 pounds, and he was now in perfect health.

RETRO-UTERINE HÆMATOCELE.

M. Regnier spoke on the treatment of retro-uterine hæmatocele at the Société de Chirurgie, and said that since 1890 he had operated 39 times successfully except in three cases. The method employed was laparotomy in 31 cases, six times for extra-uterine pregnancy from two to four months, and four times for inundation of the peritoneum. Of the cases in which he incised the cul-de-sac he had to practice once hysterectomy because the seat of the tumour was out of reach: the patient succumbed. In another case immediate laparotomy was rendered necessary from hæmorrhage. The speaker mentioned several similar cases communicated to him by his colleagues necessitating laparotomy, while one patient died from the hæmorrhage, which came on several days after the incision of the hæmatocele in the cul-de-sac. He consequently believed that laparotomy was justifiable in every case of voluminous hæmatocele, and of relatively recent date, while the small tumours should be reserved for the retro-uterine incision.

CACODYLATE OF SODA.

M. Vidal said that he had used cacodylate of soda in subcutaneous injections on several tuberculous patients, at the daily dose of from one to two grains. In the advanced stages of phthisis the treatment did not give much result. On the other hand, in the incipient stage

of the malady, the cacodylate of soda increased the appetite and the strength as well as the number of the red corpuscles with surprising rapidity. M. Hazem remarked that he had tried the cacodylate of soda in chlorotic patients, but the advantage was not very well marked, and he was always of the opinion that preparations of iron were the only specific for chlorosis.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, March 10th, 1900.

RHEUMATIC FRICTION SOUNDS.

WEINLECHNER exhibited a young woman to the "Gesellschaft der Aerzte" with peculiar sounds in both legs when an attempt was made to flex or extend them, although both were functionally disabled from a previous attack of articular rheumatism. The patellæ were normal and not displaced. A similar sound was present in the ring fingers when moved. He was unable to give any reason for this phenomenon, but thought he might commence treatment by applying a firm bandage in the extended position, with subsequent opening of the joint if found necessary.

TORSION OF THE OMENTUM.

Hochenegg followed with a specimen from a male patient, whom he also presented, æt. 41, on whom he had operated for presumable appendicitis. The history of the case excited much interest. It appears he was born as a cryptorchid, the right testicle appearing as an inguinal hernia which was afterwards kept back with a truss. In 1899 the hernia got strangulated, but was replaced with much difficulty by the taxis method.

The following day intense abdominal pain, vomiting, shivering, and tympanitis, with a temperature of 38 degs. Cent. (100.4 degs. Fahr.). In another day all the violent symptoms receded, but the general system began daily afterwards to decline. Both inguinal rings were examined but found to be free; and nothing externally could account for the declension. A little tenderness and swelling appeared later over Poupart's ligament which led to the conclusion of an inflammatory condition of the appendix on the right side.

On laparotomy being performed the transudation of blood from the whole surroundings was enormous; they were everywhere hypertrophied and œdematous, with here and there large thrombosis of the veins. On closer examination of this venous stasis it was discovered that the omentum had been three times turned on its own axis; this almost obliterated the return of the blood, and produced the morbid condition present. After removing the omentum, and closing the inguinal canals, the patient recovered without a bad symptom.

This, we think, is the first case of intra-abdominal torsion recorded in literature, although two others are reported as having occurred in a hernial sac.

CARDIAC VARIATION.

Heitler, according to announcement, gave the results of his laboratory experiments on the variable volume of the heart. He used a pericardial sac as a plethysmographic chamber.

The heart alters in volume when in a normal condition by simple blood pressure. The increase is sometimes on

the right, sometimes on the left, and often on both sides by the blood pressure alone.

Dilatation of the heart is caused by compression of the aorta, vena cava, or by irritation of the pericardium, the vagus nerve and accelerans, as well as subcutaneous injections of the ordinary salt infusion.

CARCINOMA OF SIGMOID FLEXURE.

Paltauf demonstrated, from a preparation of carcinoma taken from the sigmoid flexure of a twelve-year old boy, that the young are also subject to this disease. From 10,000 cases of carcinoma, however, he had only 19 cases to report under 20 years of age, which showed that such cases were rare.

TERATOMA—FŒTUS INCLUSUS.

He also showed a teratoma which he had removed from the back of a child, æt. 4½. This foetal growth was about the size of a child's head, covered with skin, and having distinct jaws, lips, and teeth, with hairy parts about 20 centimetres long; an alimentary and spinal column could also be traced. The connection with the midriff was not traced, but a foetus inclusus of this kind is very seldom met with.

INSPIRATORY PHENOMENA IN BRONCHO-STENOSIS.

At the Medical Club, Holzknecht related his experience with the Röntgen rays in broncho-stenosis. He brought this subject before the Society some time ago, and affirmed that the mediastinum was *always pressed towards the affected side*. The cause of the phenomenon, he avows, is due to the different balance of pressure in the two halves of the thorax. He showed a male patient, æt. 5½, who had suffered for a year and a half with difficulty of breathing and cough. Anteriorly and to the right, close to the sternum, pulsation could be both seen and felt; above this it was dull on percussion. The heart sounds were normal, except over this area of dulness, where the second sound was lost and a rushing substituted. With the Röntgen rays a shadowy mass was seen to the right of the vertebræ with indistinct pulsation. By a deep inspiration the whole mass was transported to the left side as well as the heart.

He also exhibited a female, æt. 35, who had all the symptoms of stenosis of the vena cava superior. Dulness was observed by Nothnagel anteriorly, and superiorly to the right with pleuritic effusion. The diagnosis was mediastinal tumour, which must be modified, as there was night sweating and fever with subsequent absorption, which is in favour of a tuberculous process which had compressed the vena cava. In deep inspirations all was pushed to the right side in this case also.

The Operating Theatres.

ST. THOMAS'S HOSPITAL.

INTESTINAL ANASTOMOSIS FOR CARCINOMA OF PYLORUS.

— Mr. W. ANDERSON operated on a patient, an emaciated and anæmic woman, æt. 40, who had been suffering from symptoms of dilatation of the stomach with progressive enfeeblement for nearly twelve months. During the past three months daily vomiting had occurred several hours after each meal, and it had recently become necessary to resort to rectal feeding. On examination of the abdomen a dilatation of the stomach was readily detected, but no distinct tumour could be felt; the bowels were acted upon regularly and without abnormality. Under the diagnosis of carcinoma of the pylorus it was deter-

mined to perform an abdominal section. A vertical incision was made slightly to the left of the median line above the umbilicus. On incising the peritoneum the dilated stomach was at once exposed; the hand introduced through the wound felt a large carcinomatous mass, as large as a fist, investing the pylorus. This was somewhat fixed, and although no glandular enlargement could be felt, it was judged that the patient's condition forbade the removal of so extensive a disease and it was determined to perform a gastro-jejunostomy. The first coil of the jejunum was drawn up to the level of the stomach and sutured to it by continuous Lembert's stitches; an incision of an inch-and-a-quarter in length, parallel to the long axis of the tube, was made, the lower borders of each were then sewn together by stitches passing through the whole of the coats, and the process was then continued to the upper borders, the needle passing through the whole of the coats from within outwards till the entire circumference was united, leaving an aperture of anastomosis between the two viscera. A few supplementary Lembert's sutures were then applied, and finally an outer circle of continuous Lembert was completed. After carefully cleansing the exposed surfaces, the intestine was returned, and the wound closed. The suturing occupied a period of less than half-an-hour, and the operation was well borne. Mr. Anderson said that it was very unfortunate that the admission of the patient had been so long delayed; had she come under treatment before, the whole of the disease might undoubtedly have been removed. As it was, the only resource was the establishment of an anastomosis between the stomach and the jejunum. He had hitherto found the method adopted safe and expeditious, and there was reason to hope that in spite of the patient's extreme prostration she would have a new lease of life, and a removal of the distressing symptoms from which she had hitherto suffered.

It is satisfactory to state that the next day the patient was bright and cheerful, and had suffered no shock from the operation.

GUY'S HOSPITAL.

LARGE CHRONIC ABSCESS COMMUNICATING WITH THE URACHUS.—Mr. ARBUTHNOT LANE operated on a child, æt. 2, who presented a sinus near the umbilicus leading by a funnel-shaped channel into a large, pear-shaped cavity extending into the true pelvis in front of the bladder, and running behind the symphysis. It was found on distending the cavity with milk through the sinus that there was apparently no passage into the bladder, but on distending the latter with similar fluid, some of the milk found its way into the abscess cavity and escaped through the umbilicus. The cavity was laid open from the umbilicus to the upper margin of the symphysis; its interior was found to present a granulating surface, which simulated very closely an inflamed mucous membrane. On again distending the bladder with milk, a small stream was seen to escape from a minute aperture in the upper limit of the viscus. The wall of the cavity was thoroughly scraped, and it was packed from the bottom with gauze. Mr. Lane said it was impossible owing to the softness of the parts to do anything towards closing the aperture of communication with the bladder. He remarked that the condition found was very extraordinary; personally he had never seen a similar case. It was, in his opinion, the result of an enormously dis-

tended urachus, but the peculiarity was, he thought, that it extended, not in the abdomen, but downwards in front of the bladder and behind the symphysis. He drew attention to the fact of the injected milk having passed from the bladder into the abscess cavity, but not from the abscess into the bladder, showing that the minute aperture in the upper wall of the bladder was valvular. The subsequent progress of the case was most satisfactory.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, MARCH 14, 1900.

SEXUAL DELUSIONS.

THERE are few questions which have greater importance for the profession than one which has of late years been forced on its attention by recurring instances of grave and serious circumstances in which medical men find themselves placed through groundless charges made by women who have been suffering from some ailment of their sexual organs. Closer study of the influence which such ailments exert on the mental condition of the woman has more clearly revealed her irresponsibility in the commission of various acts, and in her attitudes, whether of a domestic or social character, to those with whom she is brought in contact. The time has gone by when the old obstinacy that characterised judicial utterances and legal opinions in refusing to acknowledge such irresponsibility resulted in many a cruel and unjust decision. Modern lawyers, with a wider insight into a subtle but no less powerful forces operating in states of disordered mentalisation, prompting to acts which, to the older and more superficial observers, were regarded as criminal and responsible, have come to view the narrow boundary line of "a knowledge of right and wrong" as one impossible to maintain in the present advance in psychological knowledge. Slowly the legal attitude has given way before the

mass of medical proof which has clearly established the irresponsibility for certain acts which are the direct or indirect outcome of mental instability. This change possibly has not altogether been achieved through the work of medical psychologists, but has followed from the better education of the public mind generally, through anthropological work carried out in various directions, which has demonstrated the influences of heredity, consanguinity, alcoholism, and disease in the nervous system in the causation of insanity and crime. True, it is often most difficult to draw the line which separates the borderland of mental from that of moral responsibility. And this we fear, for obvious reasons, must ever be so. To isolate and fix a morbid impulse which has as its resultant some vicious propensity or criminal act, so as to establish a causal relationship between the two, must often be impossible, so inscrutable to the keenest and most cultured observation are the train of phenomena and the correlated influences which, stage by stage, lead up to mental and moral obliquity. All we can do in the majority of instances is to search for some strong and palpable proof of periodical temporary or permanent states of aberration. It often happens that we are helped in our search by physical and physiological conditions which are or have been coincident with the detected alienation. Taking for example the question in which we are now more specially interested, namely, the correlation existing between certain physiological phases through which the woman passes at different periods and under certain circumstances in her life, and the mental effects of these as shown in her temperament, moral acts, vicious tendencies, eccentricities, and varying shades of mental instability, we have ample proofs of such correlation. In the address recently delivered before the British Gynaecological Society, and which appeared in our columns, there was ample verification of such a relationship. At puberty, during adolescence, in pregnancy and lactation, and at the climacteric, ovarian insanity of various types is frequently manifested, and such insanity is not necessarily associated with any discoverable disease in the sexual organs. It is the associated functional disturbance consequent upon either the appearance or disappearance, excess or suppression, of the catamenia. Such is the all-powerful influence on the woman generally of the process of ovulation. The ovary in its secretion, in its periodical discharge of that function, with all its reflex potentialities and nervous excitations, becomes for the time being an irresistible factor in the being of the woman. The ovary, rather than the uterus, "is the woman." As a consequence, we are not surprised to find that, with predisposing tendencies, associated physical affections have at these times corresponding psychical developments, and that these latter are frequently of a morbid nature. If this be so, when we can detect no morbid state of the genitalia, how much more are we likely to find abnormal ideas and beliefs attendant upon diseased

states of the sexual organs! Observation has so frequently shown this connection to exist, that psychologists now include in their classification of mental diseases such forms as those of "ovarian," "climacteric," "hysterical," "old maids" insanity, as well as that of pregnancy. Not that it can by any means be demonstrated that the morbid impulses have their origin in some pathological condition in any of the woman's sexual organs, indeed, frequently such evidence is entirely absent. Still, in disorders of menstruation, in various affections of the adnexa, accompanying uterine fibromata, in the pathological changes in the uterus occurring either post-partum or at the climacteric, we meet antecedent states preceding the appearance of the disordered mentalisation sufficiently often as to establish the correlation we have referred to. This is more convincingly shown by the cure of the mental state by operation; also we have to remember those cases of post-operative insanity in which melancholia and mania, with various delusions, illusions, and hallucinations, occur as a consequence of gynaecological operations, certainly in a greater proportion than we find after other operative procedures. With all these facts before us, it is surprising that we do not more frequently find both transient and persistent delusions arising out of the necessary treatment of the sexual organs of women by their medical advisers. Such patients are often already reduced by physical suffering and incidental, yet unavoidable, circumstances associated with these affections, to a condition, both physical and mental, in which any suggestion or pernicious influence will start a morbid train of ideas, soon fixing themselves in the mind of their victim as realities. The obstinacy and persistence of such ideas are brought into stronger relief by the fact that the sufferer may be perfectly sane in all her other ideas and actions. Not necessarily is she included in the class in which we might expect such manifestations. She may not come under any of the sub-divisions into which we rather loosely divide neurasthenia. She is not "erotic," "emotional," "hysterical," or "vicious." Though, of course, it is more generally among the latter types that we do find the evidences of sexual insanity. A ready prey to charlatans of all kinds, to hypnotisers, palmists, clairvoyants, *et hoc genus*, are all such. And there is hardly any conceivable impression that such rogues may not make on their plastic imaginations.

The moral to be drawn from these facts is, that every medical man, be his position what it may, has to be always on his guard when his professional duties bring him into contact with a woman suffering from any sexual disorder. He cannot be too careful in protecting himself when advising operations, in making examinations, or in conducting treatment. By having a nurse or some friend of the patient present, or at least in close proximity, by taking short notes of his opinion or treatment at the time, he will protect himself against grave and baseless charges. Notwithstanding all this care, however, there still remains, as in the case just now concluded, risks for which no possible forethought or precaution can provide, to which all medical men are subject.

In this last instance the sympathy of all his professional brethren has been extended freely and warmly to Dr. Peter Horrocks.

THE REPORT OF THE ANTI-PLAGUE INOCULATION COMMISSION.

THE Report of the Indian Commission appointed to inquire into the subject of protective inoculations against plague has been issued in a form that presents the findings of the Commissioners, subject to the possibility of a few minor alterations. The broad result is encouraging for the future of this particular branch of serum-therapy, although its failure to establish a series of definite scientific conclusions must come as a disappointment to the enthusiasts of preventive medicine. The difficulties of this task have been simply enormous, and the Report practically amounts to an admission on the part of Mr. Haffkine that he has failed to obtain sufficient data to place his prophylactic serum among the established truths of medicine. Happily there appears to be no doubt in the minds of the Commissioners as to the value of the inoculations when the matter is weighed in an empirical balance. Many of the difficulties have been due to the character of the native population, which is full of the sloth, superstition, and apathetic fatalism familiar among Oriental nations. Indeed, it says much for the tact exercised by Mr. Haffkine and his fellow-workers that they have induced so many natives to submit to the operation. The motives that led to acquiescence appear to have been of a mixed nature. In some instances the natives surrendered to the friendly pressure of their chiefs, but more often it appears that they desired to secure certain privileges extended to the inoculated, such as the right of travelling without restriction, and of early dismissal from the segregation camps set apart for persons who had been exposed to infection. Those who have any acquaintance with life in India will readily believe that the natives who submitted to the process were generally influenced neither by the fear of death nor by the belief in the curative or preventive efficacy of the serum. This complacent attitude on the part of the native population is encouraging, as the future success or otherwise of plague inoculation in India must clearly depend chiefly upon its continuance. From this point of view it is fortunate that the administration of the serum is not attended by any serious inconvenience. Mr. Haffkine injected a large dose beneath his own skin, and was not prevented thereby from attending to his official duties, although next day he experienced a good deal of pain about the region of the puncture. Mr. Haffkine appears to have worked in the face of great difficulties, and it speaks volumes for his energy and strength of character that he succeeded in producing large quantities of the prophylactic serum and in using it upon many thousands of natives. An initial fallacy in the observations lies in the fact that the serum has not been standardised. The Commissioners in one part of their report insist on the necessity for the accurate

standardisation of the fluid, as being essential to the best results, by way not only of the attainment of protection but also of its duration. They point out, moreover, that such accuracy would probably do away with the necessity that now and then arises under present conditions of employing two successive inoculations. It appears that the strength of the serum was ascertainable only by the extremely rough plan of testing the turbidity of the fluid by holding it up to the light. By this means the amount of the dose was determined, and in the case of weak solutions no less than 20 cubic centimetres were required to obtain the desired effect. The drawback of so large a dose will be apparent when we learn that the degree of local inflammation to a great extent depends upon the quantity of fluid injected. The turbidity, it may be well to remind the readers, is due to the dead bodies of the bacilli which are contained in the clear nutrient medium in which they have been cultivated. Mr. Haffkine appears to attribute different characters to these two constituents, inasmuch as he believes that one confers protection, while the other controls the severity of an existing attack. That view, however, does not seem to have been established, indeed the balance of probabilities apparently lies in the other direction and shows that the virtue rests in the turbid portion of the serum. The Commissioners have had to reject the returns from the majority of districts for various reasons, as for example the existence of errors in statistics serious enough to falsify conclusions; the fallacy of attacks and deaths due to invasion contracted shortly before and after inoculation; variations in local virulency of plague; and the want of uniformity in the serum employed in different places. Notwithstanding doubts and difficulties of this kind, however, the Commissioners have been able to endorse the value of protective inoculation in broad and general terms. Their position has been ably summed up in the *Times*, which has all along taken an advanced scientific position with regard to this important question, in the following passage: "There is good reason to believe that, whenever inoculation has been extensively performed, the inoculated persons have yielded a smaller proportion of cases of plague, and the cases a smaller proportion of deaths, than were furnished by like numbers among those who were not inoculated; but the statistics do not appear to have been kept upon any uniform plan, nor have the conclusions based upon the figures been such as would always commend them to actuaries." Upon the whole, this Report appears to afford hope of solid future achievement in a field where the progress of preventive measures is surrounded by most formidable obstacles.

ANTI-VIVISECTION.

THE Society of Friends has issued to the medical profession an address on this well-worn subject which we feel is entitled to respectful notice, not only because of the benevolent and thoughtful source from which it emanates, but because of the modera-

tion of the language which it uses, and which contrasts very favourably with the hysterical vapourings of the average anti-vivisectionist. Nevertheless we apprehend that the Friends do not expect any number of our profession to agree with their line of argument, and we certainly do not. The advocacy of anti-vivisectionism is built upon the following statement:—"Members of the profession tell us that vivisection has added to our knowledge, and given some relief to human suffering. . . . We cannot believe that it is right that weaker creatures should be deliberately tortured by man, however beneficial to him the end in view." As regards the first of these propositions, we say that we positively decline to discuss the question whether "vivisection has added to our knowledge, and given some relief to human suffering." We must take that for granted, inasmuch as, in the world of scientists and the medical profession, not more than a dozen (including Mr. Lawson Tait and Dr. Berdoe), have ever dissented from it and, indeed, we should regard any third year's student as very ignorant of his business if he was unable to produce irrefutable evidence of its truth. Therefore, assuming it to be true, we may discuss the question whether "weaker creatures should be deliberately tortured by man, however beneficial to him the end in view." The Friends' Society say that the "more or less forcible suppression of his natural feelings of compassion, and of chivalrous tenderness towards creatures weaker than himself," would be a "ruinous price to pay for knowledge." Needless to say that we by no means concur in such a statement, for we hold that the gain which has accrued to humanity by vivisectional experiment would be amply sufficient atonement for pain inflicted on hundreds of guinea-pigs and rabbits, though, be it noted, we are perfectly aware that a large proportion of these experiments are conducted without any suffering whatever. The Friends' Society seeks to impress its humanitarian sentiments upon our profession because ours "is the high privilege of labouring, often with much self-sacrifice, to preserve the physical life of our fellow-creatures." Does it not occur to the Society that it would be wicked for scientists to abstain from using the most trusted means to preserve the life and alleviate the miseries of the human race because of the pain inflicted on a guinea-pig or a score of guinea-pigs? We should venture to suggest that human beings should certainly come first when torture has to be alleviated or life preserved, and we submit that, in seeking to prevent the pain necessarily inflicted by vivisection of the lower animals the Antis. are trying to increase greatly that which the human race would suffer from disease if it were not permitted to overcome such disease by vivisectional experiment, not to speak of the material loss which would accrue to the community from the premature disablement or death of useful earners. For our own profession we must challenge emphatically the suggestion that it is necessary for a surgeon to "forcibly repress his natural feelings of

compassion and of chivalrous tenderness towards creatures weaker than himself" when he is compelled to inflict pain on a patient. To say that he does so is an unmerited libel on him which it is not necessary that we should refute.

Notes on Current Topics.

Exoneration in the Divorce Court.

THE sensational divorce case that last week claimed the attention of a special jury ended in a way that is both satisfactory and unsatisfactory. The co-respondent, Dr. Peter Horrocks, the well-known assistant obstetric physician of Guy's Hospital, was dismissed from the suit, on the finding of the jury that he had not committed adultery. In the case of the respondent, however, they could not agree as to whether she had or had not committed adultery. The suit was brought by the husband, a medical man, upon the written confession of the wife to the effect that the father of her child was Dr. Horrocks, who had attended her professionally. Later, she withdrew that statement, which she declared to have been made while she was labouring under a delusion. Dr. Horrocks denied the charge against him upon oath. The case illustrates one of the peculiar dangers that place the reputation of a medical man at the mercy of a woman of weak mind. In this case the conduct of the respondent suggests mental disturbance of such a degree as to raise the question of how far she should be allowed out of systematic control in the future. One aspect of the case deserves comment, namely, the attitude of the legal advisers of the gentleman who brought the suit. It must have been perfectly well known to them that the wife withdrew her incriminating statement, and that the co-respondent denied the charge *in toto*. The absurdity of allowing a case of the kind to become public property is evident, for the veriest tyro in legal matters could have predicted the result of a retracted and uncorroborated confession. It is not easy to understand how responsible legal advisers can be found to conduct such a case.

The Exemption of Hospitals from Rates.

WE congratulate the President of the Local Government Board on not having committed himself to anything more definite than an expression of sympathy in replying to the delegates who had approached him for the purpose of urging the importance of legislation for exempting hospitals and infirmaries from the payment of local rates. We are by no means opposed in principle to the maintenance, or partial maintenance, of hospitals by municipal subventions, but from every point of view it is desirable that such financial assistance should take the form of direct contribution to the funds, thus leaving the matter within the control of the ratepayers. We are fully aware that precedents for such exemption abound, we would it were otherwise, but an evil is not minimised by extending its scope, and we heartily deprecate any further departures in this direction. If

this process is allowed to go on unchecked our hospitals will gradually merge into poor-law infirmaries, and the latter will consequently become supererogatory, but in the meantime the expense of running, two or more or less parallel sets of institutions will be greatly increased. In the large cities especially the system would press very heavily on the local ratepayer, who would thus be constrained to contribute to the medical care of large numbers of provincials who come to the large general hospitals in order to get the best possible advice and treatment. No, if the voluntary contribution hospital system cannot be kept going, let us frankly admit the fact and call upon the public to approve the principle of rate-subvention, and we see no valid reason why this should not take the form of a special rate. By the time this comes to pass it is to be hoped that the medical profession will be sufficiently organised to be in a position to protect itself against further abuse of medical charity on a scale previously unknown.

Compulsory Notification.

THE first prosecution in Ireland of a practitioner under the Notification Acts, as far as we can recollect, took place last week in Bray, co. Dublin, when the sanitary authority sued a local practitioner for having neglected to notify a case of diphtheria. He had attended the patient for what he described as a bad sore throat, and at the time he had informed the sanitary sub-officer that, in his opinion, the ailment was nothing more than this. According to his own testimony he was confirmed in that view, because the child got apparently well, and it was not until sixteen days afterwards that paralysis supervened which led him to believe that the disease might originally have been diphtheria. The patient died, and the cause of death was entered on the death certificate by the practitioner as "diphtheria (?)." The prosecution against the doctor was dismissed, the presiding Magistrate saying that it "was unfortunate that the doctor did not notify when he came to the conclusion that it *might be* diphtheria, but, as a doubt existed, the case would be dismissed." This case forcibly illustrates the hopeless weakness of notification law. The practitioner is in fact bound to notify when he "becomes aware" that the disease is infectious, and he is neither bound nor justified in doing so on mere suspicion. If he does so he may be mulcted in heavy damages, as Dr. Hadden, of Rathmines, was, for notifying a case which turned out not to be infective. Supposing that the practitioner desired to conceal the nature of the disease, which often occurs, no one could prove the case against him because no one but himself could testify as to the symptoms, and, if it were a mistake in diagnosis no prosecution could be sustained against any man for want of diagnostic skill. In fact, the compulsory notification law is ridiculous. It may be of use because it inculcates with authority a useful precautionary proceeding, but it can very rarely be enforced against the practitioner, and, in fact, has never been so enforced in even a dozen cases throughout the kingdom.

The American Cyanide of Mercury Case.

A STORY which, if not true, is, at least, well concocted, is told by the *Herald*, with reference to the recent conviction of a society man for poisoning a lady by sending her a bottle of bromo-seltzer dosed with cyanide of mercury. It is stated that Professor Walter Scheele, a chemical expert, having noted in a German book that cyanide of mercury is decomposed by free carbonic acid, such as exists largely in bromo-seltzer and is thereafter not hurtful, tried the experiment, and found that the statement is true and that, in presence of the carbonic acid, the hydrocyanic acid at once escapes. He, thereupon, went to the *Herald*, and offered to test the accuracy of the experiment on himself, but the authorities of the journal declined the responsibility. They, however, suggested that the Professor might try it on guinea-pigs in their presence, which he consented to do. When the occasion came, a guinea-pig was injected with the cyanide, and, of course, immediately died. Then a mixture of that drug with the bromo-seltzer was prepared, and the Professor prepared to inject. To the horror of those present he forthwith drank the entire mixture, and then prepared a mixture of tinct. ferri. perchlorid, which he enjoined them to administer to him in case he should appear to be sick, as it is a perfect antidote to the cyanide. Professor and guinea-pigs are reported perfectly well.

Cancer and Meat Diet.

THE late Mr. Charles Moore, surgeon to the Middlesex Hospital was, we believe, the first to draw attention to meat diet being a probable cause of cancer. The subject, of course, has often been referred to since then, that is to say, since 1865, when Mr. Moore first discussed it, and the opinion has for many years prevailed among those who have paid attention to the subject of cancer that the meat eating propensities of our race were in a measure responsible for our high death-rate from malignant disease. Within the past week Sir Mitchell Banks discussed this matter in his Lettsomian Lecture before the Medical Society of London, in which he expresses himself as being quite in accord with this view. Two facts in this connection must be admitted, first that cancer is increasing and secondly that an increased consumption of animal food among all classes has taken place during past years. The augmenting death-rate from cancer, although disputed by some, is nevertheless generally admitted to be proved by the figures in the Registrar-General's returns, while common observation shows that from the lower classes upwards, owing to general prosperity, animal food is more largely consumed than was the case in previous times. Sir Mitchell Banks thinks that the better classes eat infinitely too much now-a-days, but in this regard it should not be overlooked that there is a counteracting influence in the amount of physical exercise, and out-of-door pursuits to which resort is made. Again with regard to the lower classes the author believes that workmen fare admirably, and yet we should remember that quite possibly the

cancer producing effect caused by improved habits of living is considerably modified by their arduous occupations, and that the real result of their increased consumption of animal food is that of keeping them in better health, and rendering them less liable to seek the aid of hospitals. However, there is one aspect of this question about which no room for dispute exists, and that is for persons, both men and women who lead sedentary lives the present custom of high living is absolutely harmful and inexpedient from a health point of view. Medical men nowadays frequently come across patients who are obviously overfeeding themselves. Such overfeeding may be merely the result of an acquired bad habit, but unfortunately the ill-effects of the latter have generally become manifest before advice is sought. However, after the lapse of a few more decades the good influence of the exercise fostered by the use of the bicycle should begin to display its presence in an increase of the nation's health; possibly we may have in this the solution of the problem of how to reduce the mortality from cancer.

The Psychology of Courage.

COURAGE is not so much an absolute as a relative quality, and as it is made up of several physical factors it necessarily varies greatly according to circumstances. It is well known that the condition of the stomach, whether full or empty, has a great influence on the psychical condition of the individual in this respect, but *ceteris paribus* the excitability of the vaso-motor system appears to be the prime factor in bringing about the state of mind which we call courage. If the reaction to stimulus be prompt and sustained the central nervous system receives an adequate supply of blood to enable it to cope with the emergency, and an acceleration of the heart beat is therefore the first indication of such reaction. Failing this enhanced circulation the feeling of inadequacy is translated by mental distress, palpitation, trembling of the limbs, and, in severe cases, relaxation of the sphincters. In the average individual it takes a variable length of time for equilibrium to be re-established after receipt of the initial stimulus, and until it has come about, no decided action can be taken. The courage which comes gradually in the course of a few seconds or minutes is often more enduring and trustworthy than the *elan* which subsides as the magnitude of the danger dawns upon the consciousness. Curiously enough courage is not incompatible with a certain, and even marked, degree of nervousness or, shall we say, apprehension. No man in presence of imminent and obvious danger, unless he possess the power of temporarily inhibiting thought altogether, can help experiencing apprehension, but if his vaso-motor system is in good trim he may still command sufficient will power to constrain the recalcitrant flesh to do that which it instinctively abhors. The highest form of courage after all is that called for on the part of commanding officers under the influence of some unforeseen catastrophe. Under these trying circumstances temporary mental paralysis may ensue, and this is the

simple explanation of many a military failure, more or less catastrophic.

Gunshot Wounds with Mauser Bullets.

FROM the accounts published of the wounds inflicted on our troops by the Mauser bullets it may be inferred that it is, so to speak, a humane bullet, usually occasioning but little pain or hæmorrhage in traversing the body and limbs of the soldier. This may be adduced in its favour in contrast with the vastly more destructive effects of the old spherical bullet of bygone wars, or the big Snider bullet of more recent times. The special features of the Mauser bullet wound probably owe their character to its greater velocity and smaller diameter than the older projectiles, with, consequently, less strain upon the tissues through which it passes. There may be a modulus of elasticity inherent in the human tissues which is exceeded by the passage through them of the more slowly moving and more bulky old round bullet, which causes them to give way and be torn and disrupted from their connections beyond the immediate track of the projectile. This collateral action would give rise to extreme pain and cause laceration of blood vessels and nerves beyond those actually cut by the foreign body in its track. On the other hand, the swifter, less bulky, and more pointed bullet would probably glide through the tissues under the modulus of their inherent elasticity, thus leaving them in a condition to close again after the passage of the projectile, and so sealing up the track from bleeding. This unimpaired elasticity would allow the nerves and blood vessels to resume their normal positions without being torn or over-stretched, and would account for the diminution of pain and hæmorrhage following upon wounds by the Mauser and similar gunshot missiles. The aseptic character of these rifle wounds may possibly be explained by there being less air and *debris* driven in front of the pointed and narrower bullet. Waves of air are seen in instantaneous photographs to precede the missile like a buffer, and the wave of air following the base of the ball would in great part be shut off by the sphincter action of the elasticity of the penetrated tissues. Under the above circumstances grave shock to the system would be minimised in consequence of the lightning-like transit of the bullet through the body, provided it does not endanger the integrity of nerves or blood vessels.

The Housing of the Working Classes.

FROM the Annual Report of the Medical Officer of Health for Bath we learn that the problem of housing the working classes has received careful consideration in that ancient city. Bath is not by any means overcrowded, and the central parishes, where the poor chiefly live, are far less congested than they were seventy years ago. Many of the tenement houses were at one time the dwellings of aristocrats, and have thick walls, wide passages, and lofty rooms, while most of the streets are well open to light and air. Bath has its slums, however, and

in order to deal with them two schemes have been undertaken. The first really amounts to a street improvement scheme, but it provides for the erection of forty small cottages above flood level to replace twenty-seven artisans dwellings which have been demolished. The Local Government Board have sanctioned a loan for £10,500 for this scheme, and the work of raising the ground is now in progress. The second scheme is under Part I. of the Housing of the Working Classes Act, 1890. It is proposed to demolish forty-seven cottages, and to erect instead thirty cottages, four double tenement houses, and two detached houses. The cost of purchase and of clearing site is estimated at £5,690, the cost of erecting cottages £5,520, while £2,153 is cost chargeable as street improvement, total £13,663. The Local Government Board inquiry was held on February 12th, but the result is not yet known. Bath is to be congratulated in having a City Council which does not limit its building schemes to the erection of municipal offices, technical schools, and an art gallery, of which the citizens are justly proud, but also finds time and energy to improve the dwellings of the poor. Such a policy is likely to lead to the continued prosperity of this fashionable health resort.

A. Fatal Case of Post-Vaccination Pemphigus.

AN exceedingly rare sequelæ of vaccination has recently occurred at Derby. A recruit of the Yorkshire Light Infantry was vaccinated along with several others by the local military surgeon at Pontefract. So far as can be gathered from the newspaper reports this took place last December and his arm being affected he was sent back to Derby where he suddenly developed acute pemphigus. In that condition he was admitted to the Derby military hospital, where he died at the end of February. In the course of evidence it transpired that the vaccinating surgeon used glycerinated calf lymph supplied by the Army Vaccine Institute at Aldershot. Last year he vaccinated over 600 recruits, and in one case only had a bad result, when in December a soldier was attacked with acute pemphigus, from which he ultimately recovered after a severe illness. The jury found that deceased died from pneumonia, following upon vaccination. This unfortunate occurrence demands a most searching official inquiry into the methods pursued at the Aldershot vaccine station, and also the way in which the operation was performed. It is usually held that a properly prepared glycerinated lymph can hold no extraneous organism in a living condition. In both the above cases, however, the fluid appears to have conveyed a specific pathogenic organism. Pemphigus is a symptom, and often means the supervention of bullæ upon an inflammatory lesion. But in certain cases it appears to be due to a specific micro-organism, and is sometimes met with in butchers. At first sight it certainly looks as if the disease owed its origin to the calf lymph from Aldershot. A close investigation and

full report would have great value from a scientific point of view, to say nothing of the necessity of safeguarding the absolute purity of Government lymph.

Lead Poisoning in the Potteries.

IN the year 1898 special rules were established for the protection of workers in dangerous processes connected with the manufacture of earthenware and china. The step they inaugurated was received with a chorus of satisfaction throughout the country, and it was hoped that for the future, at least, one fruitful source of lead-poisoning had been removed from our midst. It is one thing, however, to print regulations and quite another to enforce them, a proposition that has been crisply illustrated by a batch of prosecutions brought by Miss Anderson, the Principal Lady Inspector of Factories, against certain pottery manufacturers. Messrs. Doulton were prosecuted for not supplying sufficient and suitable washing conveniences for workpeople engaged in dangerous processes. The magistrate, Mr. Wright, dismissed this case, as he declined to enforce the standard of the 1898 rules. The reason for this decision is not clear, as the rules have been in force for eighteen months, and it was not disputed that fourteen workers were in a lower room without lavatory accommodation, and that four basins existed in the upper room for the use of thirty-five workpeople. Messrs. Boote were fined for employing two workgirls without a medical certificate of fitness. Messrs. Burgess and Lee were fined for employing an unregistered girl, and for not cleansing the floor of the dipping-room. Messrs. Minton had neglected to provide overalls for workers employed in colour dusting, and were mulcted in £2 and costs. Thomas Poole, of Longton, was fined for employing a girl without the written sanction of the certifying surgeon. His defence was that he was unaware of the dangerous nature of the employment. It is to be hoped that these prosecutions will convince pottery makers that Government intends to enforce these emphatically just and desirable preventive measures.

The Physician as Executioner.

THE paths of philosophy at times lead those who head them into thorny and difficult positions, where notoriety is perhaps the most tangible outcome of the effort to construct an edifice of practical ethics with the bricks of extreme theory. The mantle of world-wide notice appears to have fallen upon the shoulders of Dr. Nehemiah Nickerson, a New England physician. That worthy man, having the courage of his opinion, has published his belief that if a patient suffering from incurable disease wants relief from his miseries a physician is doing a work of mercy by helping him to end his life. The field of professional ethics thus opened up is a wide one. It is easy for any medical man of experience to recognise the train of circumstances that has led to the above quoted proposition which, in its sensational boldness, more than maintains the paragraphic reputation of our American cousins. Some idea of the kind must

have forced itself upon the minds of the least imaginative medical man while standing at the bedside of a patient in the latter stages of some terrible and hopeless malady, such as cancer or general paralysis. In former days the sufferer would have been afforded euthanasia by the administration of narcotic drugs, but the resort to such remedies, even in hopeless conditions, has become vastly lessened in modern practice. If it were possible for the law to recognise the legality of a physician shortening life in the way indicated, he would stand more or less in the light of a public executioner, for every case would have to be tried upon its own merits. Other curious questions would arise. For instance if the medical attendant could take away a patient's life under certain circumstances, surely the patient himself would be allowed to do so. In other words, *felo de se*, would be legalised. Dr. Nickerson may be thanked for introducing a leavening element of novelty into the arid desert of medical journalism.

Regulation of the Status and Qualifications of Public Analysts.

THE Local Government Board have issued an order prescribing the "proof of competency" which local authorities are directed to exact of candidates for the post of public analyst under Section 3 of the Sale of Food and Drugs Act (1899). In regard to the candidates' knowledge of analytical chemistry, therapeutics, and microscopy, the Board suggests that the diploma of Fellowship or Associateship of the Institute of Chemistry of Great Britain and Ireland, together with the certificate granted by the Institute after an examination in therapeutics, pharmacology, and microscopy, might be accepted as sufficient documentary evidence of skill and knowledge. The possession of a medical diploma is regarded as affording adequate proof of competency in microscopy and therapeutics, but before a medical practitioner could be appointed public analyst he would have to furnish other evidence of a knowledge of, and skill in, analytical chemistry.

Medical Society of London.

THE hundred and twenty-seventh anniversary dinner of this society took place at the Whitehall Rooms, Hotel Metropole, on the evening of Wednesday last, Dr. Frederick Roberts, President, in the chair, supported by an unusually large number of fellows and their guests. The sister societies were represented by their respective Presidents, including Sir R. Douglas Powell, Bt., Mr. Pearce Gould, Mr. Alban Doran, Dr. de H. Hall, &c. After the usual loyal toasts, proposed by the chairman in his most exuberant vein, had been duly honoured, he passed on to the toast of the evening, that of the Society itself. He dwelt affectionately upon the many interesting details of its early history, and claimed for it a maternal relationship to most of the existing *soi disant* sister societies. He referred incidentally to the fact that they were privileged that evening by the presence of two of the senior fellows, Dr. Stocker, the Master of the Apothecaries' Society

who joined the Medical Society in 1848, and after serving as secretary for two years remained on the Council for ten years, and Dr. W. Smiles, who was elected a fellow in 1845 at a time when the society met in Lettsom's House, Bolt Court, E.C. This gentleman, he recalled, served as vice-president and honorary secretary, and received the silver medal of the society. The toast of the Visitors, proposed by Mr. Bryant in felicitous terms, was responded to by Surgeon-General J. Jameson, C.B., Director-General of the Army Medical Service, who referred to the method of dealing with the wounded in the field. He said that the results of abdominal surgery in the field hospitals had not been very successful, whereas soldiers wounded in the abdomen who were left quiet in many instances recovered. He pointed out that it was very undesirable to expose wounded soldiers to a long railway journey too soon, as the wounds almost invariably became septic *en route*. Lastly, he said that women nurses in a field hospital were far from being of service, on the contrary they were a nuisance, for reasons into which he entered at some length. Sir R. Douglas Powell also responded for the visitors. The President also proposed the toast of the Council, the Honorary Secretaries, and Mr. Hall, the Registrar, and referred in very complimentary terms to the services which the latter had rendered to the society. The intervals between the toasts were agreeably filled by musical selections rendered by Dr. Henning Belfrage, Mr. Preston Wynne, Dr. Campbell Pope, and lastly by a stirring song given in his old form by the genial President.

Anti-Vaccinationism at a Discount.

THE "conscientious" party in the Liskeard Board of Guardians have had to give way under pressure from the English Local Government Board. They proposed to appoint an anti-vaccinationist as a vaccination officer of one of their districts, but, upon the refusal of that Board to sanction the appointment, they have been compelled to advertise for such functionary with the ignominious proviso that "no anti-vaccinationist need apply."

The Midwives Registration Bill.

THE opponents of this measure will need to throw their utmost energies into the Parliamentary opposition to it. We have already reported that its promoters were most exceptionally lucky in getting a favourable place for it on the Notice Paper, but it was not at all expected that it would make any progress beyond first reading as it came third in a group of Bills which were certain to be debated at length on the same day. When the first of the group was called on the Leader of the House sought to adjourn the whole of the Bills, but was forced to give way before the clamour which arose, and the result was that, when the House was exhausted by the first two Bills the Midwives' Bill slipped through, though opposed by Mr. T. P. O'Connor. It has now been sent to a Grand Committee, where strenuous opposi-

tion will be necessary, as it will scarcely be possible to stop the measure if it comes back to the House with the endorsement of that Committee. The feeling of the profession towards it may be judged from the fact that out of 6,300 practitioners who responded to a request from the *Lancet* for an expression of their opinion, 4,000 declared their hostility to it, and only 1,311 were favourable.

A Flourishing Colonial Medical Society.

THE Medical Society of Victoria is to be congratulated upon the prosperity to which it has attained. From the last annual report thereof we gather that the membership has now reached 289, and that the Society has a balance in its favour of £1.153. These figures not only point to good management, but also to the popularity which the Society enjoys. The leading organ of the profession in the Australian colonies, the *Intercolonial Medical Journal*, is the official organ of the Medical Society of Victoria, and its pages are often full of the records of good work done by our colonial *confreres*.

Improvement of the Public Health in London.

IT seems almost that it was only the other day that a phenomenally high death-rate for London was recorded, but it is satisfactory, nevertheless, to note that in the past week the rate was no more than nineteen per thousand, the lowest point touched since the end of November. The great increase in the previous mortality was mainly due to the ravages of an epidemic of influenza the type of the disease showing a special predilection for the respiratory organs. Fortunately the epidemic did not last long, and thus it is that the death-rate has been gradually falling. Only forty-two deaths from this cause were recorded last week. It is of interest to note that within this period one death from small-pox occurred, and that was in the case of an "unvaccinated female," æt. 23. Upon the whole, in view of the time of the year and the present unspring-like character of the climate, the public health returns must be regarded as eminently satisfactory.

Mercer's Hospital, Dublin.

THE vacancy on the surgical staff of this hospital caused by the transfer of Mr. Henry Moore to the Surgeoncy of the City of Dublin Hospital was filled on the 6th inst. by the appointment of Mr. Harry Croly, son of Mr. Henry Gray Croly, F.R.C.S.I., Senior Surgeon to the last-named Hospital. Mr. Harry Croly holds the M.D. and M.Ch. of the University of Dublin, and has acquired practical knowledge as House Surgeon to the City of Dublin and St. Mark's Hospitals. There were many competitors, most of whom we have named already.

TO-DAY (Wednesday), at 4 p.m., Mr. Godlee is announced to deliver a lecture on "Some Peculiar Cases of Empyema," at the Brompton Chest Hospital to which practitioners are invited.

THE "Female Pill" business has fallen on evil times, and a certain "Dr." Davis, who, in times past, seems to have made a good thing by the sale of these delusive nostrums, has had to tell his tale of woe in the London Bankruptcy Court. This gentleman was at one time the proprietor of a religious newspaper (save the mark!) which he subsequently transferred to someone else in deference to certain social reasons into which we need not enter. We shall be pleased to chronicle the bankruptcy of many others of this ilk.

THE death is announced of Dr. William Marcet, F.R.S., at Luxor, Egypt, at the advanced age of 71. He had been in failing health for some time past.

PERSONAL.

DR. A. M. PHELPS has been elected President of the Medical Society of the State of New York.

DR. THEODORE WILLIAMS has been elected President of the Life Assurance Medical Officers' Association *vice* the late Sir Herman Weber.

THE Duke of Cambridge will take the chair at the annual dinner of the Sanitary Institute, of which he is President, on Friday, May 11th.

DR. GARROD THOMAS, J.P., D.L., of Panteryod, Cardigan and Newport (Mon.) has been elected as a sheriff for Cardiganshire.

DR. GEORGE BUCHANAN, Professor of Clinical Surgery in the University of Glasgow, has resigned his chair for reasons of health.

GENERAL WOOD, until recently assistant army surgeon, has been appointed to the post of Governor of Cuba.

DRS. J. A. HARTIGAN, C. Seaver Smith, and T. B. Fawcus have been nominated by the University of Durham for appointments in the Royal Army Medical Corps.

MR. FAREAR, who for many years has occupied the position of solicitor to the General Medical Council, has tendered his resignation by reason of age and impaired health.

MR. F. G. FITZGERALD, L.R.C.P., L.S.A.I., has been nominated by the President of the Royal College of Physicians of Ireland to a commission in the Royal Army Medical Corps.

MR. TREVES telegraphs to the *British Medical Journal* from Pietermaritzburg to the effect that he and Nurse McCaul entered Ladysmith on Friday, 2nd inst., and found 800 typhoid cases.

SIR THOMAS NAGHTEN FITZGERALD, whose offer of three months' service in South Africa has been accepted, is the reputed head of the surgical branch of medicine in Australia. The *St. James Gazette* describes him as "a dapper little Irishman, with a rumoured income (very much rumoured!) of £50,000 a year."

MAJOR DAVID PRAIN, M.D., Indian Medical Service (Bengal Establishment), upon whom the University of Aberdeen is to confer the honorary degree of LL.D., graduated M.A. at Aberdeen in 1878 with honours in Natural Science, and took the degree of M.D. in 1884. In the same year he entered the Indian Medical Service, and attained the rank of major in 1896. He is at present director of the Royal Botanical Gardens, Calcutta, in which post he succeeded Sir George King, K.C.I.E., in February, 1898.

Manchester.

[FROM OUR OWN CORRESPONDENT.]

MEDICAL SCHOOL.—At last Manchester has set aside its prejudice, and is preparing to afford facilities for the medical education of women students. The charter of the Victoria University puts no bar on sex. Hitherto Owens College has made no arrangements for the instruction of female medicos. All this is now to be rectified. Special classes are to be formed and ample opportunities offered. Even the conservative Royal Infirmary has agreed to open its wards to the petticoated rivals. With strange perversity, however, it has been decreed that the surgical out-patient department shall be protected from the invasion of the would-be woman doctor. It is well to leave aspiring females at least one hedge further to clear. A Hall of Residence for Women, in connection with Owens College will do much to develop a proper *esprit de corps*.

WAR NEWS.—Manchester medicos are taking a keen interest in the war. Professor Tom Jones hopes to go out shortly as director of the Welsh Hospital, and will take some Welsh students with him to act as dressers. Both house-surgeons from the Salford Royal Hospital are about to sail. Other Manchester men are serving in South Africa, or are on the way out. The good news of the relief of Ladysmith was celebrated by the Manchester students with a torchlight procession. Lectures and classes were generally given up. The Professor of Medicine found the following bulletin on his black-board: "Lady Smith safely delivered. Both doing well.—Buller, M.D. No Lecture."

MEDICAL EDUCATION.—The Owens College authorities have presented the following resolution respecting instruction in chemistry and physics to the Medical Council:—"The Committee, having had under consideration the recognition of instruction in chemistry and physics in technical schools by the Conjoint Board for medical and for dental students, although not recommending any official representation to be made by the college to the technical schools, consider that it is advisable that such students should take their courses in the subjects named at a recognised medical school or university college."

THERAPEUTICAL SOCIETY.—Manchester enjoys the distinction of having the only Therapeutical Society in Great Britain. At its last meeting Professor Leech read an important paper on "Saline Baths." Other communications were given on the use of mercuriol in syphilis, and salicylate of soda in diabetes.

ARMY COMMISSIONS.—The Secretary of State for War has offered fifteen additional commissions in the Army to members of the Victoria University, comprising five in the Royal Artillery and ten in the infantry. Past as well as present students of Owens College are eligible.

MEDICAL SOCIETY OF LONDON.

THE meeting on Monday evening last (Mar. 12) opened with a paper by Mr. P. J. Freyer on "A New Method of Performing Perineal Prostatectomy," in which he premised that the vast majority of cases of senile enlargement of the prostate were best treated by careful, clean, and judicious catheterism. In certain cases, however, an operation was advisable, and, in a small minority, imperative. He related a case in which

on cystoscopic examination the right lobe was seen to be enlarged and projecting into the bladder, the size of a walnut. He operated as follows: Having opened the urethra in front of the prostate on a staff, he passed his finger through the opening. He then passed the forefinger of the other hand into the rectum, and clearly defined the tumour. The next step was a crescentic incision about four inches long from the median raphe, at the lower end of the urethral wound, backwards round the anus to the coccyx on the right side. The dissection was carried deeply into the ischio-rectal fossa. The left forefinger was then passed through the urethral wound into the bladder and hooked round the tumour, which was pulled out into the wound. The capsule of the prostate was incised and peeled off, and the tumour was removed piecemeal, only a thin layer being left to support the mucous membrane of the bladder and prostatic urethra, which was left intact. No ligatures were required. On completion of the operation a soft rubber perineal tube was passed through the urethral opening into the bladder and retained in position for six days. A fortnight later the urine began to pass partly through the urethra, and soon all the urine passed that way, and the patient made a good recovery. He claimed for this operation that it attained Nicoll's object by a much less heroic and dangerous proceeding than suprapubic cystotomy.

In the discussion which followed Mr. Mansell Moullin, pointing out that where there was a large, or indeed any, intra-vesical growth the perineal distance would be too great by this operation. He mentioned that he had performed a very similar operation three months ago, except that he had not inserted a tube. He observed, moreover, that changes occurring at the age of the author's patient ought not to be described as senile.

Mr. Swinford Edwards also criticised the title of the paper which he thought ought to have been "removal of tumour of the prostate by pararectal incision combined with external urethrotomy." He thought that for most tumours of the prostate, which were intra-vesical, McGill's operation was the best, for, though risky, it was radical.

Mr. Stanley Boyd thought the incision should be described as circumanal, and asked whether the division of the inferior hæmorrhoidal nerves, which must take place, gave rise to any inconvenience. He suggested on theoretical grounds that much better access would be obtained by turning down a large semilunar flap from one tuber ischii to the other.

Mr. Mitchell Bruce pointed out that enlargement of the prostate took place in various directions, so that no one operation could enable them to deal with enlargements in general. Until they could eliminate sepsis and ascertain beforehand what had to be removed he could not hope for a greater measure of success.

After Mr. Freyer had replied, Mr. Keetley read a paper on "Coxa Vara," based on seven cases, in five of which the diagnosis had been verified by skiagrams. Four were in females and three in males. The symptoms were principally adduction, eversion, and diminished flexion. There was absolutely no tenderness on pressure, and no history of inflammation or suppuration which distinguished these cases from hip-joint disease.

Obituary.

DR. THOMAS PETER MASON, OF DUBLIN.

THE death of this venerable member of the profession has followed close upon that of his son, Dr. Samuel Mason, which we announced a few weeks ago. He died at his residence in Dublin on Saturday, the 10th inst., verging on 80 years of age, but he had been failing in health for a considerable time. Dr. Mason was a familiar of the passing generation of the Irish profession, having taken part in medical teaching for quarter of a century. He took his first qualification as Licentiate of the Irish College of Surgeons in 1842, and his M.D. in the University of London in 1846, and the Fellowship of his College in 1852. His chief work as a teacher was in conjunction with Mr. Edward Ledwich, as lecturer in anatomy and physiology in the Ledwich School, which position he

maintained until the dissolution of the School in 1889. During most of that lengthened period he taught medicine, also as physician to Mercer's Hospital. He was a member of the Society of Friends, and was buried yesterday in the cemetery of that community.

Medical News.

Vital Statistics.

THE deaths registered last week in thirty-six great towns of England and Wales corresponded to an annual rate of 27.5 per 1,000 of their aggregate population, which is estimated at 12,784,802 persons in the middle of this year. The deaths registered in each of the last four weeks in the several towns, alphabetically arranged, corresponded to the following annual rates per 1,000:—

Birkenhead 19, Birmingham 25, Blackburn 31, Bolton 26, Bradford 21, Brighton 17, Bristol 17, Burnley 17, Cardiff 17, Croydon 15, Derby 18, Dublin 34, Edinburgh 22, Glasgow 34, Gateshead 14, Halifax 27, Huddersfield 20, Hull 19, Leeds 21, Leicester 19, Liverpool 31, London 19, Manchester 28, Newcastle-on-Tyne 19, Norwich 18, Nottingham 16, Oldham 25, Plymouth 30, Portsmouth 18, Preston 29, Salford 30, Sheffield 22, Sunderland 18, Swansea 17, West Ham 15, Wolverhampton 29. The highest annual death-rates per 1,000 living, as measured by last week's mortality, were:—From measles, 1.3 in Bristol, 1.8 in Sunderland, 1.9 in Blackburn, and 4.8 in Preston; from scarlet-fever, 1.8 in Burnley; and from whooping-cough, 1.5 in Blackburn and 2.1 in Salford. In none of the large towns did the death-rate from "fever" or from diarrhoea reach 1.0 per 1,000. The 80 deaths from diphtheria included 26 in London, 9 in Sheffield, 6 in Leeds, 6 in Leicester, 5 in Portsmouth, 4 in Glasgow, 4 in West Ham, 4 in Liverpool, and 3 in Blackburn. One death from small-pox was registered in London, but not one in any other of the large towns.

LORD IVEAGH has received a telegram to the effect that his hospital had arrived safely at Cape Town, and had been ordered to Naapooort.

A Nurse's Libel Action.

IN the Queen's Bench Division last week Dr. Joseph Bell, author of some "Notes on Surgery for Nurses," had to defend an action for libel based on a paragraph in this work reflecting on the conduct of an unnamed nurse, who brought an action against a distinguished surgeon for having removed more of her person than she had expected. Miss Alice Jane Beatty appropriated these remarks to herself, and claimed damages. Judgment was ultimately consented to in her favour for fifty guineas, with costs.

Death Under Chloroform.

A COLLIER, age 64, who was about to be operated upon for gangrene following an injury to the foot, died suddenly after one drachm (!) of chloroform had been given at the Wigan Infirmary. The report contains no information as to the mode of administration, and this from a statistical point of view is regrettable, because it can only be by repeated demonstrations of the danger attending the induction of anaesthetics by the so-called "open" method, on a towel or handkerchief, that the importance of using a controlling apparatus will ultimately be appreciated.

Training of Midwives.

LORD GLENESK, in the House of Lords on Saturday last, presented a Bill for the better training of midwives and the regulation of their practice.

The Mortality of Foreign Cities.

THE following are the latest official returns, and represent the last weekly death-rate per 1,000 of several of the populations:—Calcutta 39, Bombay 151, Madras 46, Paris 28, Brussels 21, Amsterdam 18, Rotterdam 21, The Hague 24, Copenhagen 22, Stockholm 18, Christiania 20, St. Petersburg 28, Moscow 25, Berlin 19, Dresden 18, Breslau 24, Munich 30, Vienna 19, Prague 22, Trieste 31, Rome 32, Venice 30, Cairo 35, Alexandria 25, New York (including Brooklyn) 18, Philadelphia 21.

Notices to Correspondents, Short Letters, &c.

LOCAL REPORTS AND NEWS.—Correspondents desirous of drawing attention to these are requested kindly to mark the newspapers when sending them to the Editor.

PERSONATION OF QUALIFIED PRACTITIONERS.

SIR,—In your article headed 'Personation of Qualified Practitioners,' p. 251 of the current issue of the *MEDICAL PRESS* and *CIRCULAR*, you have fallen into certain errors which perhaps you will kindly allow me to correct. The name of the impersonator was Rowland not Holland. Nugent emigrated it is true but had not died, and it was he himself, not his "widow" who rented the diplomas to Rowland for 3s. 6d. a week to be paid to Mrs. Nugent. With regard to certificates of death and Alabone, the attention of the Registrar-General was called to a particular case some years since by myself as Secretary of the Medical Defence Union, but without avail.

I am, yours truly,

A. G. BATEMAN.

Medical Defence Union, 4, Trafalgar Square, W.C.
March 7th, 1900.

SOLDIERS' BABIES.—The proprietors of Mellin's Food have been inspired with a happy idea in offering to supply their well-known food gratuitously to the babies whose fathers have been killed in the war. They ask the assistance of practitioners in discovering eligible claimants, and we have no doubt our readers will be pleased to communicate this generous offer to those whom it may interest.

PROFITABLE ADVERTISING.—Presiding at a recent meeting of Bovril, Limited, Mr. J. Lawson Johnston said that the special circumstances obtaining towards the end of the year afforded exceptional opportunities for an advertising campaign, of which the directors decided to avail themselves, with the result that the sales up to date showed an increase of over 150 per cent. over the corresponding period of last year. The result having been achieved without taking into account the large Government orders received in connection with the war in South Africa.

DR. A.—Your communications have not reached us, and we have had to deal with the matter in their absence.

Meetings of the Societies and Lectures.

THURSDAY, MARCH 15TH.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.—5 p.m. Dr. F. J. Waldo: Summer Diarrhoea with special relation to Causation and Prevention. (Milroy Lecture.)

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Tichborne Street, Edgware road).—Clinical Evening. The following cases will be shown:—Dr. H. Tilley: Cholesteatomata of Mastoid.—Mr. F. Jaffrey: Urticaria Pigmentosa.—Dr. W. Harris: Progressive Muscular Atrophy.—Dr. L. Guthrie: Cerebellar Tumour.—Dr. H. J. Maccevoy: Little's Disease. And other Cases.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chancery Street, W.C.).—3 p.m. Dr. H. Low: Class. Röntgen Rays. Demonstration 11. 4 p.m. Mr. J. Hutchinson: Consultation. (Surgical.)

FRIDAY, MARCH 16TH.

EPIDEMIOLOGICAL SOCIETY OF LONDON (11, Chandos Street, Cavendish Square, W.).—8.30 p.m. Paper: Dr. Robinson: Measles, its Distribution and Control.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 p.m. Prof. C. Stewart: On the Protection and Nourishment of the Young in Plants and Animals.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chancery Street, W.C.).—4 p.m. Dr. R. Tilley: Consultation. (Eye, Ear, Nose and Throat.)

ROYAL ACADEMY OF MEDICINE OF IRELAND.—Obstetric Section. —Papers. Dr. Kidd: Notes on a Case of Round Celled Sarcoma of Ovaries.—Dr. Cole Baker: Porro's Operation Complicated by Myoma and 5½ months' Pregnancy. Dr. Macan: Atmo Causes and Zesto Causes.—Dr. Alfred Smith: On Treatment of Inverted Uterus.—Dr. Glenn: Schucking's Operation for Retroversion of Uterus with Cases.—Specimens. Dr. Alfred Smith: 1. Inverted Uterus with Tubes and Ovaries. Panhysterectomy. 2. Interesting Specimen showing Appendix Vermiformis and Ovary, forming an Abscess Cavity. 3. Pyosalpinx two Cases.—Dr. Macan: 1. Solid Ovarian Tumour. 2. Fibro-cystic Tumour.—Dr. Smyley.—Dr. Purefoy.—Dr. Glenn: Parovarian Cyst.

Appointments.

BEALE, H. R., L.R.C.P., M.R.C.S., has been appointed House Physician to St. Thomas's Hospital.

BOURDAS, E. C., L.R.C.P., M.R.C.S., has been appointed House Physician to St. Thomas's Hospital.

CARTER, HORACE, H. A., L.R.C.S., and L.R.C.P.Irel., has been appointed Assistant Medical Officer in the Colonial Service.

CLEMENTS, JOHN EDMUND, M.B., B.Ch., B.A.O., R.U.I., has been appointed Medical Officer to the Chinese Customs Service.

COUPLAND, SYDNEY, M.D.Lond., F.R.C.P., M.R.C.S., has been appointed Consulting Physician to the Middlesex Hospital.

DUDGEON, L. S., L.R.C.P., M.R.C.S., has been appointed House Physician to St. Thomas's Hospital.

FAGGE, C. H., M.S., F.R.C.S., has been appointed Surgeon to the Out-patients of the Evelina Hospital for Sick Children, Southwark Bridge Road, London.

GATES, E. A., L.R.C.P., M.R.C.S., has been appointed House Surgeon to St. Thomas's Hospital.

JARDINE, ROBERT, M.D.Edin., M.R.C.S., L.F.P.S.Glasg., has been appointed Examiner in Midwifery to the University of Glasgow.

KILVERT, J. E., L.R.C.P., M.R.C.S., has been appointed Ophthalmic House Surgeon to St. Thomas's Hospital.

PEARSON, C. Y., M.D.Irel., F.R.C.S.Eng., has been appointed to fill the Chair of Surgery in the Queen's College, Cork.

POWELL, Sir R. D., M.D.Lond., F.R.C.P., M.R.C.S., has been appointed Consulting Physician to the Middlesex Hospital.

SKEEN, WILLIAM, M.D., M.S.Lond., F.R.C.S., L.R.C.P., has been appointed Surgeon on the Staff of the Imperial Yeomanry Field Hospital.

YARROW, G. E., M.D., L.R.C.P.Lond., M.R.C.S., has been re-appointed Surgeon Accoucheur to the City of London Lying-in-Hospital.

Vacancies.

Birmingham and Midland Eye Hospital, Birmingham.—Assistant House Surgeon. Salary £60 per annum, with apartments and board.

Bradford Royal Infirmary.—House Surgeon for twelve months, unmarried. Salary £110 per annum, with board and residence.

Cardiff Infirmary.—Assistant House Physician for six months Salary at the rate of £50 per annum, with board, washing, and apartments. Also Resident Medical Officer for three years. Salary £100 per annum, with board, washing, and furnished apartments.

Cumberland and Westmorland Asylum, Garlands, Carlisle.—Junior Assistant Medical Officer, unmarried. Salary £100 a year, with board and residence.

Devon County Asylum, Exminster, Devon.—Third Assistant Medical Officer. Salary £120, rising to £150, with board and residence.

Down District Asylum.—Assistant Medical Officer. Salary £100 per annum (to be increased to a satisfactory officer) with furnished apartments, board, washing and attendance. Applications to Resident Medical Superintendent (See Advt.)

East London Hospital for Children and Dispensary for Women, Glamis Road, Shadwell, E. Medical Officer for the Casualty Department for six months. Salary at the rate of £100 per annum. Luncheon is provided at the Hospital.

Great Northern Central Hospital, Holloway, London.—Junior House Surgeon for six months. Salary at the rate of £30 per annum, with board, lodging, and washing in the hospital. (See Advt.)

Hants County Asylum, Fareham.—Third Assistant Medical Officer, unmarried. Salary £125 per annum (increasing to £150 after twelve months' service), with furnished apartments, board, washing, and attendance.

Hartlepool Hospital, Hartlepool.—House Surgeon. Salary £80 per annum, with board, lodging, and washing in the Hospital.

Loughborough and District General Hospital and Dispensary, Loughborough.—Resident House Surgeon. Salary £100, per annum, with furnished rooms attendance and board.

Metropolitan Hospital, Kingsland Road, N.E.—House Physician, House Surgeon, Assistant House Physician, and Assistant House Surgeon for six months. Salary for House Physician and House Surgeon at the rate of £40 a year each. Salary of Assistant House Physician and Assistant House Surgeon at the rate of £20 a year each.

Royal National Hospital for Consumption, Ventnor.—Clinical Assistant. Board, residence, and laundry provided. Apply to the Resident Medical Officer. Also Resident Medical Officer, unmarried, Salary £150 per annum, with board and lodging in the Hospital. Apply to the Secretary to the Medical Committee, at the Hospital, Ventnor.

Royal Surrey County Hospital, Guildford.—House Surgeon Salary £80 a year, with board, residence, and laundry. Also Assistant House Surgeon, £30 a year, with board, residence, and laundry.

Sheffield Royal Hospital.—Junior Assistant House Surgeon, unmarried. Salary £50 per annum, with board (no wine or beer), lodging and washing.

St. Mary's Hospital School, Paddington, W.—Demonstrator of Physiology. Salary £100 to £150.

York Dispensary.—Resident Medical Officer, unmarried. Salary £110 a year, with board, lodging, washing, and attendance.

Births.

GIBBS.—March 11th, at Claytons, Bourne End-on-Thames, the wife of Francis R. Gibbs, M.B.C.S., L.R.C.P.Lond., of a daughter.

HOOLEY.—On March 4th, at Broxmere, Cobham, Surrey, the wife of Arthur Hooley, L.R.C.P.Edin., M.R.C.S., of a daughter.

Marriages.

PAKES—FISHER.—On March 1st, at St. Andrew's, Fulham, by the Rev. Charles Pakes B.A., Vicar of Copp, Garsington, father of the bridegroom, assisted by the Rev. J. S. Skinner, B.A., brother-in-law of the bride, Walter Charles Cross Pakes, L.R.C.P., D.P.H., to Dora Agnes, youngest daughter of the late John Fisher, Esq., of Leconby, Gt. Eccleston, Lancs.

Deaths.

HERON WATSON.—Feb. 27th, at Gotha, Germany, Elizabeth Gordon Miller, wife of Patrick Heron Watson, LL.D., M.D., F.R.S., F.R.C.S.E., and L. Surgeon-in-Ordinary to the Queen in Scotland, and daughter of the late James Miller, F.R.S., F.R.C.S., Professor of Surgery in the University of Edinburgh, and Surgeon-in-Ordinary to the Queen in Scotland.

SIMSON.—March 2nd, Francis Taylor Simson, L.R.C.P., L.S.A., of Montagu Place and Craven House, Northumberland Avenue, W., aged 40.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

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Original Communications.

GENERAL PARALYSIS OF THE INSANE (a);

BEING THE ABSTRACT OF A LECTURE

By FLETCHER BEACH, M.B., F.R.C.P.,

Physician to the West-End Hospital for Diseases of the Nervous System.

THE causes of this disease may be divided into two classes, the physical and the moral. The chief physical causes are sexual excess, chronic alcoholism, syphilis, cranial injury, and heredity. Sexual excess is quite as common in married men as in single. You often find a man who has led a dissipated life, marrying a young wife, and general paralysis resulting. Heredity accounts for one-third of these cases. Syphilis is also a very important cause. A short while ago, at a prolonged discussion at the Pathological Society of London on the subject of syphilis in relation to tabes and general paralysis, it was agreed by all the speakers that syphilis accounted for three-quarters of the cases of tabes and general paralysis; Dr. Mott was of opinion that 90 per cent. was not too large a proportion, though, personally, I should differ with him on that point. The stress and strain of intellectual labour also account for a large number of cases.

Turning to the moral causes of general paralysis of the insane we find anxiety about business matters a very frequent cause, especially in the case of a man who has a wife and large family to provide for on an income at no time too large. Prolonged intellectual labour, especially when accompanied by a large amount of physical work, is also an important cause.

As regards age, general paralysis of the insane usually occurs between 30 or 40 years of age, *i.e.*, when a man has attained the prime of life. Men who have led a fast life, and arrived at the age of 30, very often break down, general paralysis resulting. Cases occur in the young and old. Some time ago I made an inquiry into the subject of juvenile general paralysis. In 36 cases of this form including my own there were children varying from 5 or 6 years of age up to 15 or 16, so that, comparatively speaking, juvenile general paralysis is not so rare as senile general paralysis. Taking the question of sex, it is found that males are affected four times as often as females; this is easy to understand, because men are subjected to considerable strain and anxiety related to business matters which do not affect women. Cases, which occur in women, are as in men, mostly due to syphilis, but there is not the same tendency in women to general paralysis of the insane that there is in men. I have scarcely ever seen ladies of the highest class of society subjects of this disorder. It occurs most frequently in men of the lower classes of society, decreasing in frequency

in men of higher social position, then come women of the lower classes, and finally women of good social rank, in whom, indeed, general paralysis is rarely, if at all, seen.

You may get general paralysis of the body without mental symptoms, and I have seen many cases of that kind in this hospital.

Premonitory symptoms are very important for this reason, that at the stage when these symptoms come on, most good can be done. General paralysis of the insane is most generally seen by general practitioners in this stage, and, therefore, it is necessary to know what to look out for. The most common moral symptom is perversion of moral sense. This perversion is shown by the fact that a man who has all his life been moral, suddenly becomes a thief. Another symptom is very great irritability of temper. Loss of determination of character is also seen in business men, who wish to take some strong line in a certain matter but are quite unable to decide on their plan of action, though previously they were successful, hard-headed, shrewd men. Another fact indicating perversion of moral sense is indelicacy of manner in men who have been previously upright and polished; and they may even indulge in debauchery and licentiousness. An educated and refined man often becomes rude, coarse and blasphemous of tongue, and will give way to lying and dissimulation.

Intellectual change is the next most important symptom. Of course, this disease, like all cases of insanity, is a dissolution. The highest faculties are the first to dissolve; thus the memory becomes weak as in old age. The patient will recall events long passed very clearly, but he is quite unable to remember recent events. There is also a good deal of absent-mindedness, and the patient will forget to keep business appointments that he has made. In addition to that weakened faculty, there is great mental confusion; the patient is unable to make any calculation, no matter how simple. This intellectual perversion sometimes takes the form of violent passion. Sometimes these patients get hypochondriacal. The patient says he cannot swallow anything because his throat is stopped up, or he will not take any food because he has no bowels, and therefore cannot defæcate.

On the other hand, the patient may become very excitable; this excitability will be shown by irritability, restlessness and instability. He has plenty of energy in business matters but no foresight or judgment. Another of these unfortunate signs is self-assurance. The patient will sometimes make large purchases of useless articles and even ruin himself by so doing. Together with these symptoms, there is generally sleeplessness and a feeling of drowsiness after meals.

The physical premonitory signs of intellectual dissolution in general paralysis are severe headache, neuralgia of the head and limbs, or of the viscera. The patient will complain of a feeling of a ball in his

(a) Delivered on Thursday, February 22nd, 1900.

throat or of fullness in the stomach. There are also a number of subjective symptoms, such as, sparks in front of the eyes, general feeling of cold, crawling sensation in the limbs. There is also loss of power in the lower extremities, or locomotor ataxy may be noticed in the spinal form of general paralysis. You may find temporary loss of speech with tremulous muscular movements. The pupils will be contracted or unequal not responding to light. Occasionally there are severe convulsive seizures. All these symptoms will not, of course, occur in one case.

After a few months, or in some cases a few years, the case will pass into the first stage of general paralysis. In the first stage the chief symptoms are mental exaltation, ideas of grandeur and increased restlessness and excitement accompanying grandiose ideas. The patient boasts of his titles and fabulous riches and herculean strength, and generally he has most absurd ideas in his head. I remember a patient telling me, when I was resident physician at Bethlem, that he had been riding on a comet, but it was so hot up there that he came down to the earth again.

There is a difference between the ideas of grandeur in ordinary cases of insanity and in general paralysis of the insane. In the former, the patient believes in the delusion and sticks to it through thick and thin, while in the latter the patient will forget on one day the grandiose ideas of the previous day and will have different ideas on the next day; the mind is so confused that he cannot remember his delusions. In this first stage, the man is still more addicted to buying quantities of useless articles. Many instances of this are known. The general restlessness is seen in the constant walking about the room, singing, talking, disarranging the room. There is great destruction of the clothing and the patient takes his food in a slovenly way, spoiling and messing his clothes; he becomes careless of his appearance. Hallucinations of sight and hearing are frequent. The chief physical signs of the first stage are tremor of the lips and tongue, slurring of speech, indistinct utterance, contracted and unequal pupils not reacting to light, and a vacant stolid expression. The hands are tremulous and consequently the handwriting shaky. If you notice a general paralytic writing a letter, you will see he leaves out the vowels and some words and even sentences, and sometimes he alters their position or makes something up to insert. There is also anaesthesia and weakened sense of taste. Increased knee-jerk. Temperature normal, or varying from 99 to 100 or 101 degs.

There is a gradual transition usually to the second stage, which may be accompanied by epileptic fits. The chief symptoms now are mental enfeeblement and muscular weakness. The fits may be either of the "haut mal" or "petit mal" type; occasionally they are very violent and so frequent as to cause the patient to remain for some time unconscious, or even to die. These fits of epilepsy in general paralysis of the insane are distinguished from the fits which you get in epilepsy by the facts that the general paralytic patient does not bite his tongue or make any cry, and that the convulsions are not so severe. In epilepsy the mental symptoms are absent. As a rule, when patients get fits, they are men far advanced in life who have led a fast life. When the patient recovers from the fits, he passes into a state of mental deterioration, which is shown by weakened memory, by unstable emotional condition, and sometimes by hallucinations. The man has no power of initiating a scheme, he does not force his grand ideas down your throat with his previous energy, though he still admits their truth, if questioned. He gradually loses power in his legs, though he will tell you he can walk miles, when he can hardly

walk a few steps. I had one such patient who could barely walk from one end of my consulting-room to the other, and yet he said he could walk miles. The face is heavy and dull of expression, the man puts on flesh and becomes quite contented—a very bad series of symptoms. The tremor of lips and tongue is increased, the speech hesitating, the tone of voice changed. The pupils are dilated and unequal, and insensible to light. No knee-jerk, temperature normal, ordinary sensibility is lost. The patient may remain like this for years. As a rule, they soon pass into the third stage which is characterised by inarticulate speech, paralysis and mental depression. He puts out the tongue with difficulty. Meat must be minced to prevent choking. Speech becomes more and more indistinct. Gait is unsteady. Urine and faeces are passed involuntarily. The patient dies after diarrhoea, or lung complications have supervened. To illustrate my remarks, I will show you two cases.

CASE 1.—A medical man, *æt.* 53, with history of syphilis. He was admitted to the asylum in October last. Previous to admission his wife said: "He has become more irritable and more easily excited; his appearance and habits, which were very neat and orderly, have lately become untidy." He had also attempted to make large investments in shares quite beyond his means. He had a busy country practice, and he seemed to break down under the increasing work which it involved. On admission, right pupil was larger than the left. Pupil reflexes were very brisk. Knee jerks, plantar reflex, and others exaggerated. Lingual and facial tremors were present. Slurred speech. He was very talkative, and offered everyone he met large sums of money and cases of champagne; he said he attended 200 confinements in one night at 100 guineas apiece, &c. He has considerable loss of memory for recent and past events, and is impulsively violent and excited at intervals. During the last three weeks, he has become more demented, dirty in his habits, and has difficulty in swallowing. He is physically weaker and there is rapid wasting.

CASE 2.—J. B., *æt.* 41. Seaman, Royal Navy. No history of insanity, syphilis, or alcohol. He was only admitted to the asylum last January, six weeks ago, suffering from advanced general paralysis of the insane. Quite unable to hold the simplest conversation, and requires constant attention. Pupils unequal. Reflexes very exaggerated. Tremors very marked. Considerable loss of co-ordinating power in the finer movements. Characteristic general-paralysis-of-the-insane speech. He falls about when moving. Very dirty habits. Marked difficulty in swallowing. Complete loss of memory. He has attacks of violence and once tried to kill his wife and injure himself by jumping out of the window. His only grand idea is that he commanded H.M.S. "Condor" at the battle of Alexandria.

With regard to these cases, which by the kindness of Dr. Edwards I have been able to show you, I would say that the age of the medical man (53) is beyond my limit, but you must remember that he has been suffering for some years. This is a good instance of the grandiose delusions.

In Case 2, where the patient is about to reach the third stage, it is extraordinary that the reflexes are still exaggerated as they ought to be almost absent at this stage.

There are several varieties which do not always take the course I have given you. Some cases begin with melancholia and hypochondriacal delusions instead of mental excitement. These delusions are nearly always fear of poisoned food, and that some one is going to kill the patient. Instead of melancholia, the case may begin with dementia, with gradual impairment of memory, and loss of wil

power; there will be sleeplessness, destructiveness, and uncleanness in habits, and forgetfulness, mental confusion, headache, sluggishness, offences against public decency, and criminal assaults. Many of the cases of indecent criminal assaults are cases of general paralysis of the insane in the early dementia stage. There is another form, which begins with locomotor ataxy, which may have existed for years. The disease spreads up the spinal cord, and the brain is greatly affected. This is the "ascending" or "spinal" form of general paralysis, and generally occurs in patients younger than those of the ordinary cases. Another variety commences with lateral sclerosis. The chief symptoms of lateral sclerosis are excessive myotatic, irritability. The knee-jerks and ankle clonus are greatly exaggerated, and some of the muscles of the thigh and leg as well as those of the arm will contract easily by tapping their tendons in suitable positions. The gait is spastic, and the foot is dragged. The duration of cases of general paralysis varies from a few months to a few years; as a rule the patient dies in the course of a few months. Cases are known to have gone on for ten to fifteen years, but they are rare. In some cases there is a remarkable remission of symptoms. Such patients have been discharged from asylums as recovered, but they come back as bad as ever in a year or eighteen months. One fact about these cases is that, however much their mental condition is improved, there is generally, more or less tremor of the lips and tongue, and irregular pupils and feebleness. They are unfit for the ordinary cares and worries of business life, and, indeed, would break down if they resumed their previous work. There is one practical point in reference to these discharged cases I would lay stress upon. If the patients possess property, they are made wards in chancery on admission to an asylum: on discharge, they will do all in their power to get a medical man to make an affidavit to the fact that they have recovered, which, of course, you must never do if there has been a history of general paralysis; for his improvement simply amounts to remission of symptoms.

Prognosis.—It is bad, the disease always ending in death.

Diagnosis.—There are many diseases which you may mistake for general paralysis of the insane, the most common being, syringomyelia, diphtheritic paralysis, multiple peripheral neuritis, disseminated sclerosis and bulbar paralysis. It is this symptom (bulbar paralysis), occurring as a complication in the diseases just mentioned, which makes them at all like general paralysis. In bulbar paralysis the tongue, lips, soft palate, pharynx, and larynx are paralysed, and so the patient cannot articulate properly, and there is difficulty in swallowing and preventing saliva running out of the mouth. In the initial stage it may be mistaken for general paralysis, but the condition of the pupils, the tremor of the lips and tongue, and the mental symptoms are absent in bulbar paralysis.

Treatment.—This is preventive at first and medicinal afterwards. Marriage of insane persons must be prevented because the children are sure to be neurotic and become insane, probably at the period of puberty. With reference to the individual, we must see that the patient has no overstrain in education, the faculties must be developed equally in a normal manner, with plenty of time for exercise in fresh air and amusements. Self-reliance and self-restraint must be imposed on the patient. When he leaves school, he should have some regular occupation, such as that of a clerk in a Government office or some Civil Service department. In the case of a working-man, there is less chance of mental strain; but even with him, the outdoor life of a labourer is better than the heated work-room of an artisan.

Diet is important. No alcohol of any kind must be allowed. Girls at the age of puberty must be watched very carefully, for this is a critical stage in their life. If the premonitory symptoms I have mentioned above have taken place, it will be necessary to remove the patient from his occupation and send him to the country, where he is under different conditions and leads a regular life free from any excitement. He should rise early in the morning and have a cold bath, and should either ride, drive, golf, or cycle in moderation in the morning; with ladies, fancy work or literature or exercise is useful. As of old, the great thing is to keep the head cool, the feet warm, and the bowels open. If the disease is fully established, the first thing is to remove the patient from home; if he is rich, take him to the seaside with an attendant, but it is best to place him in an asylum or similar institution; only when the symptoms are slightly marked, is it right for him to live in a doctor's house or with an attendant. His food must be light, spare, and easy of digestion. Warm baths and plenty of exercise are valuable, and the bowels should be kept open. Later on, the amount of food may be increased. You must be on the look out for bed sores, to which such a patient is very liable. Let him have a water-bed, and place cotton wool over the bony prominences, for he is generally wasted. When bed-sores have formed, dress with borax lotion or dusting powder (starch and zinc oxide in equal quantities).

As regards the medicinal treatment, if the man is excitable, bromide of potassium (20 grains every four hours) is useful. Some physicians have suggested digitalis, 20 minims every three or four hours. Purgatives are necessary. If he cannot sleep, potassium bromide and chloral, or better still, trional, is the best thing. The latter, which I have tried extensively, does not seem to have the disagreeable after-effects which follow repeated doses of sulphonal; trional also seems to produce more refreshing sleep. I never give more than 15 grains of trional in ordinary cases, but when the patient is a general paralytic I double the dose. If the depression is severe, perchloride of iron, arsenic, or quinine, are valuable in keeping up as much as possible the patient's strength. If the man has epileptic seizures, bromides must be given every three or four hours, and enemata of brandy, eggs, and peptonised milk, having first cleared out the intestines with enemata, may be given. If the patient is apoplectic, the bowels should be kept open by calomel, cold should be applied to the head, and bromides should be administered.

The Lettsomian Lectures.

PRACTICAL OBSERVATIONS

ON

CANCER OF THE BREAST. (a)

By SIR WILLIAM M. BANKS, LL.D., F.R.C.S.

Surgeon to the Liverpool Royal Infirmary; Emeritus Professor of Anatomy in University College, Liverpool.

LECTURE II.

SOME POPULAR ERRORS IN DIAGNOSIS.

THERE are some delusions about cancer of the breast in which almost the entire public still have faith, and I regret to say, not a few medical men. There is the error as to heredity, as to pain, which is merely dependent on local circumstances and in respect of cachexia, which is often only a terminal symptom.

Nipple retraction and skin adhesion are signs of some importance, but any error with regard to these

(a) Delivered before the Medical Society of London, Monday, March 19th, 1900.

can only be made by the doctor and not by the patient. The absence of nipple retraction is not a diagnostic sign in cases where the disease is situated away from the centre of the gland, but, on the other hand, it is practically pathognomonic when it lies beneath it.

Adhesion of the skin is a very grave indication of a sublying cancer. It does not occur with any other tumour, except an inflammatory swelling of the nature of an abscess, and there is a different appearance between the skin in the two cases.

CONDITIONS MOST CLOSELY SIMULATING MAMMARY CANCER.

We have to distinguish between chronic mastitis, small chronic abscess, a small fibro-adenoma, and a small tight cyst, and in these there is no absolutely diagnostic sign; indeed, experience alone enables one to decide whether or not there is malignant disease.

In connection with the diagnosis of mammary tumours there are one or two points of practice which, if employed as a matter of routine, might save an operator from occasionally falling into an error of what may be termed a public character. (1) *I never remove a breast without first cutting into the tumour*, so soon as the patient is anæsthetised, and on sundry occasions I have been extremely glad that I did so. I acknowledge to constant mistakes, being aware that omniscience is the exclusive property of very young men. (2) *I frequently use a small exploring trocar and canula for diagnosis*. I know that this practice has been much condemned. I was taught that it was very dangerous, but I found by practical experiment that it was nothing of the sort. It was held that it inflamed the tumour and accelerated its growth, and so if the tumour were inoperable it did damage to the patient. This view was quite true, because surgeons formerly put large and dirty trocars into the interior of solid tumours and inoculated them with septic material. If an exploring trocar and canula, with a metal handle be used, which can be boiled and then passed through a spirit tube, no harm whatever will result. On the contrary, many dubious questions can often be settled at the cost of a most trifling amount of suffering and to the enormous mental relief of the patient. (3) *I always examine a breast tumour in three positions*. In examining (say) the left breast in the first position the surgeon should stand behind the patient, with his left arm passed beneath her left armpit and his right arm over her right shoulder. The surgeon should be steady on his feet and the patient should be asked to press back against him. He can thus regulate the pressure he is putting on with his hands to a nicety, and make the best possible use of his sensibility. When the breast is examined from the front the surgeon puts a certain amount of pressure on it, and the patient yields from it, and so the judgment of weight, so essential to determining the nature of a soft body, is lost. In the second position the patient should be seated in a firm chair, and the surgeon should examine the breast from the front. In the third position the patient should be on her back on a sofa. Now in each of these positions the surgeon will acquire a new appreciation of the tumour, but the first is by far the most effective, for in it he will avoid the mistake, so liable to be made in the other two (especially the third) of crumpling up a mass of sound tissue so that it comes to feel just like a tumour. All things under the chin, down the neck in the breasts and in the groins should be examined by the surgeon standing behind the patient.

After discussing the occurrence of acute mania after operations on the breast, the author proceeded to deal with

CHRONIC MAMMARY INDURATION—CHRONIC INTERSTITIAL MASTITIS.

My next subject is chronic inflammatory induration

or chronic interstitial mastitis, which Billroth calls chronic cirrhotic mastitis. One form is known as diffuse chronic mastitis. The most common form with which we are all acquainted is what pathologists call the "periductal" form; the *maladie noueuse* or plexiform fibroma of the French. Surgeons here call it chronic interstitial mastitis. It seems to be simply a very slow and painless variety, where the inflammatory process confining itself strictly to the neighbourhood of the glandular tissue proper, results in a fibrous sclerosis. Bits of the gland may be affected or the entire organ. In the latter case the breast feels like a hard pancake, which you can lift up from the subjacent great pectoral muscle. All through it are scattered hard masses from the size of a pea up to that of a broad bean. Besides these larger pieces there are little minute nodules scattered all through the gland. The microscope shows these to be small cysts, structures produced in all tubular glands under cirrhotic conditions.

Thus, then, if a chronic mastitis continue to progress by developing more and more connective tissue, then what happens is the production of a cirrhosis with the formation of small cysts, and finally with completed shrinkage of the whole breast, this process being accompanied by the formation of nodules almost approaching the characters of small fibroid tumours. The disease is essentially one of the climacteric period, and in my experience seems to be as common in single as in married women.

The principles of treatment of chronic mastitis by pressure, gentle friction, and the use of local remedies, such as used to be called "discutients," seems to be reasonable. My routine practice is to direct the breast to be bathed for five minutes morning and evening with hot water applied by means of a big cone-shaped sponge. Then there is rubbed into it mercurial ointment one week, and liniment of iodide of potassium with soap the next—the inunction being done with the greatest gentleness. After a while this treatment is apt to make the skin of the breast very tender, and produce crops of painful little pustules. It should be entirely left off, and soft zinc ointment smeared on until the skin irritation has subsided. Stays must be abandoned, and the breast covered with a layer of cotton wadding. Pressure is applied by means of a broad elastic webbing bandage. The first turn is brought round under the armpits and fastened with a safety pin, and then the patient can pull on the remaining turns as they go down over the mamma as tightly as she can bear, fixing it at the short ribs with another pin. The patient may take a moderate dose of iodide of potassium morning and evening, unless it proves very disagreeable to her, but after all it is without doubt in the local treatment that confidence is to be placed.

The degeneration of chronic interstitial mastitis into cancer is, of course, perfectly familiar to all operating surgeons. But I very much doubt if this knowledge is as thoroughly diffused throughout the profession as it ought to be, or rather I should say that I question whether medical men at large attach to it the immense importance which the matter deserves.

In doubtful cases the above treatment should be tried, but in suspicious cases when the balance of probability is that the cancerous limit is being reached, even when to the touch no absolute certainty thereof is communicated, I have for many years practised and taught that removal of the breast is a justifiable proceeding. By cutting through any suspicious mass or nodule, I am quite sure that the section which an experienced surgeon makes with a knife through a fresh piece of carcinoma will enable him to give a far more decided and certain opinion than anything the microscopist can give. When the

results of microscopical examinations differ from the conclusions derived from the history of the tumour, and the look and feel of the fresh section, the latter, I believe, constitute the most trustworthy guide.

I have seen several cases of chronic mastitis in men, and curiously enough they have all been in private practice, one of the things that, I think, produces it in them is the rubbing of braces and brace buckles, and these of course must be at once removed and a belt worn. The course of treatment above-mentioned seems to be perfectly successful.

At this stage the question naturally arises, if the transition from chronic interstitial mastitis into cancer is a thing whose occurrence is admitted by all surgeons, can we guess in what proportion it occurs? Here it seems as if statistics were of no avail whatever. What attempts have been hitherto made have lost weight by reason of the fact that they have included all kinds of mastitic trouble. Now my contention is that the mastitis out of which or in which carcinoma develops is of one kind and of one kind only—viz., the chronic interstitial mastitis, which arises spontaneously about the middle period of life, and has nothing to do with any previous inflammatory condition. Putting aside infantile and adolescent mammary abscess the only other acute inflammatory condition which arises in the breast of moment is milk abscess. It occurs in women during the active child-bearing period between 18 and 35. When opened, drained, and cured all traces of inflammatory induration disappear in their sites. I have seen breasts the subjects of "rabbit warren" milk abscesses, which I have literally cut to pieces, which have healed so remarkably that the scars of them have been no great disfigurement, while the breast tissue has been as supple and soft as if nothing had been wrong with it. Again in examining all kinds of female breasts for all sorts of trouble I have found the scars of incisions few and far between, and of a very simple nature.

I cannot therefore agree to the statement, copied from one book to another, that acute milk abscesses leave behind them permanent indurations which degenerate into carcinoma, or that the scars, made for their relief, are similarly dangerous. Chronic interstitial mastitis of the menopause—*voilà l'ennemi!*

My friend and colleague, Mr. Paul, while unable to fix a percentage, believes most firmly that a much larger number of cases of chronic interstitial mastitis are allowed to drivel into cancer than is commonly believed.

It is universally admitted that the essential feature of carcinoma consists in the escape of epithelium from the interior of the alveoli into the surrounding connective tissue and its subsequent proliferation there, this cancerous epithelium differing but slightly from the normal variety. It is clear that the ultimate reason for its proliferation must always be incomprehensible to us, involving as it does, the principles of life and growth. Gland epithelium is always growing and always perishing and always being eaten up or discharged. So long as the balance between growth and waste is even there is health; when growth exceeds waste there is neoplastic disease. Apparently as soon as the epithelial cells escape from their normal habitat and get into the spaces that exist between the connective tissue fibres, they increase at a great rate. Why? This is the crux of the whole question. Some hold that the irritation produced by parasitic bodies excites the growth of epithelium in ultimate alveoli or tubules and carries on the excitement when the epithelium has burst its bounds and escaped into the cellular tissue.

Is it possible to trace the gradual development of a piece of carcinoma in a chronic interstitial mastitis. The earliest change probably consists in the appearance of quantities of leucocytes, which constitute a

round celled infiltration, distributed in the neighbourhood of the ultimate lobules. The single layer epithelial lining of the tubules and acini, which compose the ultimate lobules, then begins to proliferate and grow into the interior of these cavities. At the same time there is a production of a new and very delicate connective tissue which surrounds the tubules and acini of each ultimate lobule. The normal connective tissue outside of that also increases largely in bulk, by reason of all which things many tubules are so squeezed and strangulated that, their distal portions being cut off, there is no exit for their contents, and they therefore become distended, and form the innumerable little closed cysts which are found all through the cirrhotic breast of chronic mastitis. Matters may remain thus for long enough, the breast shrivelling more or less. This is the cirrhotic change already alluded to. But another change may occur. The growth of the epithelial cells in the tubules and alveoli may go on to such an extent that they become completely blocked up, and appear as black areas on microscopic section. The fine interacinous connective tissue does not increase much in this case. But the ducts and acini, becoming more and more distended, eventually meet and fuse into each other. So that in place of a number of small black areas we now see large ones, still giving slight evidences of the agglomerated acini of which they are composed. These masses of cells, however, are still held together by the surrounding interlobular tissue and by the limiting membranes of the original ducts and acini. But finally even these give way, and the cells pour out into the strata of the connective tissue. They creep along between the bundles of connective tissue, following the tracks of what are probably the very earliest commencements of the lymphatic system, rapidly reproducing themselves by the process of karyokinesis. They are now cancer cells, although between them and the original epithelial cells lining the tubules and alveoli there is not a great difference. There is certainly nothing absolutely distinctive. The normal glandular epithelial cell is of very regular shape and size, and has one well-marked nucleus, being an orderly growing cell. The cancerous epithelial cell varies a good deal in size and shape, being a young, rapidly-growing erratic cell. There is some difference in the way in which certain stains affect with more or less intensity the cytoplasm of the two kinds of cells, but this is not improbably due to the difference in their age. Mr. Plimmer notices that in all actively growing cancers there is a zone of round celled infiltration at the margin of the tumour where growth is most intense, and this zone does not exist in simple tumours. Near the more central parts of the tumour these round cells are converted into large mononuclear cells, and later on into fibrous tissue which surrounds the cancer cells. This stroma next causes a degeneration of the cancer cells; a digestive or phagocytic process. As time goes on the stroma hardens and serves the function of protection against invasion, so that the centre of a carcinoma is the hardest and most fibrous, and thus comes to pass the fact also that the harder the tumour—in other words, the more fibrous tissue there is in it the less is the chance either of generalisation or recurrence. So, to, we arrive at the explanation of the atrophic cancer, where the cells have been really all devoured by the connective tissue.

In the Transactions of the Pathological Society of London is a very interesting paper by Mr Cecil F. Beadles, which has not been accorded the prominence it deserves. It is based on certain histological changes found in association with glandular carcinoma. He examined microscopically nearly one hundred breasts removed for primary carcinoma. He came to the conclusion that breasts in which such tumours are

found are never in what may be called a normal state. It is often possible to make out with the finger small, hard nodules situated at a distance from the tumour and having no apparent connection with it. Sometimes, however, only slight thickenings can be felt in some parts of the breast. The acini show proliferative and other changes in the epithelium, and there are to be noticed also changes in the stroma, which comes to resemble that seen in some rapidly growing scirrhous tumours in which connective tissue cells with their elongated nuclei run parallel around the acinus, having between them what appear to be small uniform cells with round nuclei. The changes are both of the nature of chronic interstitial mastitis and, in the case especially of the thickenings and small nodules, of a condition intermediate between simple adenoma and carcinoma, extremely suggestive of commencing malignant disease. Mr. Beadles is of opinion that these changes in the apparently sound breast tissue are not produced by infection from the existing carcinoma, but are most likely due to the same causes which started the tumour. Clinically, and quite apart from all microscopic examination, this is the opinion I have always held myself: in plain language, it means that there is a precancerous state of the whole breast, which, however, only blazes up into full-grown cancer at one or two points. It was this view which made me utterly disbelieve in the removal of the tumour alone, and which prompted me many years ago to press vigorously upon the attention of the medical profession the advisability of free removal of the entire breast and with that the clearing out of the axilla.

CONTRIBUTIONS

TO THE

TOPICAL DIAGNOSIS

OF

CEREBRAL DISEASES.

By Hr. H. OPPENHEIM.

THE author reported a number of cases observed in the St. Hedwig's Hospital in association with the director of that hospital. The first was a man, æt. 30, admitted in November, 1898. Two years before he had fallen on the back of his head, had headache and giddiness afterwards, and some time later had repeated attacks of convulsions, and more recently had disturbance of speech and weakness in the right arm.

The patient showed slight dulness of intellect and had pronounced double optic neuritis. The speech disturbance was of the character of sensory and amnesic aphasia, with alexia and agraphia. The disturbance of movement was on the right side a hemiataxia, the movements of the right arm were clumsy, could only be performed under the guidance of the eye. The patient therefore preferred using the left extremities, but the strength was not diminished. Sensibility was less acute on the right than on the left. The sense of touch was lost on the left side but not on the right.

From the symptoms the speaker assumed a tumour in the left hemisphere, situated in the left temporal lobe, extending to the large ganglia, and internally reaching to the gyrus fornicatus. As the symptoms got worse, Hr. Rotter decided to trephine. He exposed the region of the left temporal lobe, slit up the dura, but found no tumour. Puncture of the first convolution gave some clear fluid; the protruding convolution was removed. As the patient awoke

there was distinct conjugate deviation, but this soon passed off. The general symptoms at first improved, the neuritis became less marked, and the disturbances of sensibility diminished. The improvement lasted two months when the symptoms got worse again, and still worse, until the patient died in deep coma in two months time. The autopsy revealed a tumour seated exactly as had been calculated.

The simultaneous existence of unilateral anosmia with temporal lobe tumours, indicated in all cases, that the tumour had already reached a considerable size, and rendered prognosis unfavourable in respect of operative interference.

The second case was that of a very intelligent young man of 23, who was ill of fever with rigors in the autumn of 1895. In a few days he felt apparently well again. Some weeks later he had a single attack of giddiness. In the spring of 1896 he again had a single attack of giddiness, with singing in the left ear, followed by twitchings of the left arm, the patient became unconscious, and then had general convulsions. These attacks followed by prolonged headaches were repeated at varying intervals.

When the speaker first saw the patient the general health was but little disturbed, and there were no pressure symptoms. In spite of this, however, he concluded that a tumour was present, on the ground of the history, as well as of right hemiataxia, and of a peculiar disturbance of sensibility. The patient was not able to recognise by the feel with the right hand simple and known objects placed before him, whilst he could with the left.

The acoustic aura pointed to the temporal lobes, the motor symptoms to the anterior central convolution. The speaker assumed the existence of a tumour at the point where these parts met.

After treatment for a year the patient returned with pronounced optic neuritis of the right eye.

Hr. Rotter then opened the skull at the spot indicated, and came upon a tumour of the cortex that was difficult of removal owing to dendritic offshoots; within the tumour was a small cyst. The tumour was a tubercle conglomerate. Death took place from purulent meningitis ten days after operation.

Unilateral ataxia could arise from disease of the motor zone of the temporal lobe, or from the anterior limb of the internal capsule. In the first instance it was associated with motor symptoms or with paralysis, mostly limited to one extremity. If it proceeded from disease of the internal capsules there was simultaneous hemianæsthesia.

A man, æt. 33, had convulsions five years ago, then after five years headaches with muscæ volitantes, convulsions again, and remained unconscious seven days. When he awoke he was blind. There was slight bulbar protrusion, bilateral amaurosis and anosmia. Tumour of the cerebellum and chronic hydrocephalus were both thought of. The patient died, and at the autopsy a tumour was found in the cerebellum and strongly compressing the left hemisphere.

The speaker also mentioned a case of carcinoma metastasis in the brain, the site of which could be localised in the left hemisphere of the cerebellum; further an otitic abscess of the left temporal lobe, without disturbance of speech, for the reason, as the section showed, that the abscess was seated in the most posterior segment of the lobe. In a case of empyema of the antrum of Highmore, the patient complained of intense, markedly localised headache. He thought the pain was hysterical, but Hr. Rotter chiselled down to the spot without finding anything. In a few days aphasia and monoparesis facio-brachialis came on. On removal of the gauze tampon the symptoms disappeared, nor did the headache return.

THE INFLUENCE OF HEREDITY ON DISEASE.

By PROFESSOR HAMILTON,
Aberdeen.

It had to be remembered that not all diseases transmitted by parent to offspring were hereditary. Many of them, e.g., congenital syphilis, were due to direct contagion, to inoculation of the fetus by the maternal blood. Putting all such aside, truly hereditary diseases must be considered like all other hereditary characteristics, and the two chief theories of heredity which met with most general acceptance were Darwin's theory of pangenesis and Weismann's theory of the germ plasm. The whole question of the heredity of disease depended on whether external influences affecting the soma could so impress the germ plasm as to cause the somatic changes to be perpetuated in the next generation. In other words, were acquired characters transmitted? While Haeckel, Virchow, and Einer held that they were, Weismann and Ziegler held just as firmly that acquired characters were never transmitted, and that hereditary tendencies were due solely to variations in the germ plasm. Ritual circumcision practised through generations had not influenced the conformation of the Jewish race in the present day, and the artificial production of physical deformities among other peoples had not been perpetuated. The classical experiments of Brown-Sequard on epileptic guinea-pigs were often quoted in support of the view that acquired characters were transmitted; these, however, were unsatisfactory, and were not susceptible of the interpretation put upon them. In answering the question whether a morbid state of the body due to external agencies ever impressed the cells of the germ plasm so that the disease became hereditary, he proposed to take up some of the better-known hereditary diseases. *Tuberculosis* was now believed by most pathologists not to be hereditary, and seldom to be congenital. But there was no doubt that, though tuberculosis itself was not transmitted, in certain families there was a marked proclivity to tubercular infection. This could not be explained by the facts that often all the members of the family lived under the same conditions, or that when one became tuberculous the risk of infection was increased. Members of such families were often recognizable by a peculiar habit of bodily conformation, and this, he believed, was hereditary. He suggested that in its essence it might consist of a vulnerability of the epithelial coverings of the body, which were too little resistant, too readily stimulated, and too easily penetrated by the parasite. There was no reason to suppose that any member of the human race was immune to the action of the tubercle bacillus (as some animals were) if it could be implanted in the tissues. In many persons, however, the power of resistance was very great. Where did the vicious strain arise? Did it ever result from insanitary surroundings? He believed not. Probably the variation had arisen far back in the history of the race, and had been propagated to the descendants ever since. *Gout* was another disease very generally believed to be hereditary. It was said to result from high living, and, once established, to be capable of hereditary transmission. But the gouty individual was one with an inherited peculiar habit of body, subject to the deposition of uric acid in the tissues, and to modification of almost all the bodily functions. Reptiles and birds excreted a large amount of their bodily waste as uric acid, and he might be allowed to suppose that the gouty habit of body was possibly a reversion to the type of a remote ancestor in whom uric acid was excreted normally in much

larger amount than was possible to the average modern individual. Of all diseases, however, the *neuroses* were the most markedly hereditary. These depended upon a derangement of cells which were of epidermal origin, and it was of interest to note in this connection that the tubercular constitution was frequently associated with the neuropathic. Might it not be that here again the epidermal structures were lacking in resistance to strain? A further point to be remembered was that nerve cells had little or no power of repair. *Syphilis* he did not regard as an hereditary disease. *Hæmophilia* was eminently hereditary, and was more probably a disorder of the blood-vessels than of the blood itself. Referring to the fact that it was translated to the males along the female line, it was suggested that it might have some analogy to menstruation. There was a certain amount of evidence of a periodic flux in the male as well as in the female. There could be no doubt that a vicious strain could be eradicated by inbreeding with a healthy stock, but the liability to its return atavistically in later generations would always be present. In maternal impressions as a cause of disease he had little belief, but he thought that there was some evidence in favour of the occurrence of *telegony*. It would be interesting to know whether any cases had been observed by the members present in which a woman of healthy stock had shown evidence of the influence of a previous diseased husband on the progeny by a second healthy mate. His conclusions were as follows:—(1) There is no evidence that diseases due to external agencies can be transmitted. (2) Hereditary tendencies to disease arise as variations in the germ plasm. (3) These variations arose far back in the history of the race, and have been perpetuated, or may arise atavistically. (4) There is little evidence of the importance of maternal impressions. (5) *Telegony* may prevail in the case of hereditary disease.

Clinical Records.

CASES OF SKIN DISEASES PRESENTING UNUSUAL FEATURES.

By DR. ARTHUR HALL,

Lecturer on Clinical Medicine, University College, Sheffield, &c.

IN a case of *lupus erythematosus* occurring in three places on the face of a youth, the treatment suggested by Hebra was tried with fairly successful results. This consists of the frequent application of rectified spirit, in which a little menthol has been dissolved. The patient carries the bottle about with him, and applies some to the spots every half-hour or oftener during the day.

The second case is one of *parakeratosis palmaris* which caused considerable annoyance, and which was relieved by the following treatment:—The hands are soaked every night in very hot water containing a small quantity of soda. They are then well rubbed with pumice stone and the following dressing applied: Acid salicylic, 10; *emplastrum saponis*, 100; olive oil (about 20) to make it pliable. This is spread thickly on a piece of linen with a warm knife, and applied over the palmar surfaces. The hands are then enclosed in simple bag gloves of linen. Next morning the dressings are removed and the hands well rubbed with ung. *acidi salicylici*. The patient works during the day, so that the treatment can only be partial.

My third case is one of *eczema capitis infantis*, in which, owing probably to neglect on the part of the mother, a spreading ulcer formed at the root of the nose, which eventually proved fatal.

I have also two cases of ringed vesiculo bullous eruption in children, affecting chiefly the vulva and surrounding parts, also the legs and the face, about the nose and mouth chiefly. The eruptions here recurred at short intervals.

Lastly, I have a case of erythema induratum, of Bazin in a young woman which has lasted for four years, recurring every autumn, and lasting all through the winter months.

I should like to refer to a simple and easy method of satisfactorily treating scabies, suggested by Sherwell, of New York. It consists in applying washed flowers of sulphur to the body, and sprinkling it on the sheets. The usual precautions as to having infected garments stove-d must be carried out. The quantity of powder used need only be very small, say one teaspoonful on each occasion. It produces no discomfort or unpleasantness and the process is repeated every second night for three times.

Transactions of Societies.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, FEBRUARY 9TH, 1900.

The President, Dr. A. V. MACAN, in the Chair.

EXHIBITS.

Dr. R. A. FLYNN showed a parovarian cyst removed by vaginal celiotomy. There were some adhesions. The patient came suffering from menorrhagia, which was relieved by curetting. She suffered a good deal from pain in her back, which seemed to get worse after operation. She also complained of pain about the umbilicus.

Dr. E. HASTINGS TWEEDY showed an ovarian cyst removed by celiotomy.

Dr. KIRKPATRICK said he examined this patient's urine on several occasions, and thought that possibly it was a case of tuberculosis of the pelvis of the kidney. The urine, however, was stained for tubercle bacilli, but none were found.

Dr. MACAN showed the specimens from a case of double ovariectomy, with papillomatous cyst.

PATHOLOGICAL OVARY, WITH MICROSCOPIC SECTIONS.

Dr. ALFRED SMITH showed an interesting pathological ovary which he removed from a patient, æt. 25, who enjoyed good health up to Christmas 1899, when her abdomen began to get distended. She rapidly emaciated, was extremely weak, and on admission into hospital no diagnosis could be made, the distension from the free ascites was so great. Exploration revealed the omentum to be quite solid, mobile, confined to the upper abdomen, and in appearance like boiled sago grains; it bled easily. The left ovary was normal; the right ovary was of normal size and consistency; showed in the fresh state numerous small whitish warty elevations, not unlike in appearance grains of boiled sago, identical in appearance to the omentum. Microscopic examination showed that these growths consisted of a delicate stroma, containing in its meshes, in a somewhat alveolar arrangement, groups of large globular degenerate-looking cells. The nucleus was eccentric, and flattened against the cell margin; in many cases it was broken up and absent, while the protoplasm, containing many oil droplets, yielded the typical fatty and mucoid reactions. In parts the growth seemed to be converted into true fat. It sprang altogether from the surface of the ovary, and did not infiltrate the subjacent tissues. The section of omentum gave same characteristics. The fluid in the abdomen was light brown, or straw-coloured, but it contained no blood.

CLINICAL REPORT OF THE ROTUNDA LYING-IN HOSPITAL FOR 1898-1899.

Dr. PUREFOY brought forward his Report which was read in part.

Dr. A. SMITH criticised the absence of the date of entry into and departure from hospital of patients. He pointed out that a new expression (mixed hæmorrhage) had been introduced as a form of accidental hæmorrhage, and he considered the use of this term a mistake, as it was quite unnecessary. It was curious that several of these accidental hæmorrhages occurred rather early in

pregnancy. He pointed out cases occurring in the 8th, 7th, and 6th months, and he thought it was not proved satisfactorily that these were really cases of accidental hæmorrhage. The statement as to the exact value of the plug and binder in cases of accidental hæmorrhage was too dogmatic. As to the time of application of the forceps, the former teaching of the Rotunda Hospital was, he thought, after four hours in the second stage. He considered it a great improvement that the time test had been left out in the present report, the indications laid down being dangers on the part of the mother. There was a case of locking of twins recorded, but on reading the account he could not agree that they were locked at all in the ordinary sense. On page 12 of the Report the serrenceud was stated to have been employed in a Porro's operation. He himself would not think of using a serrenceud at all, and he did not see why they should go back to the old Porro's operation when they had modern methods of doing it. He congratulated Dr. Purefoy on the mortality, which was very low, and on the state into which he had brought the morbidity of the house. The hospital still maintained its high position among similar institutions.

Dr. W. J. SMYLY pointed out a case of threatened eclampsia just commencing labour in which two bougies were passed into the uterus. They were taught hitherto that one of the fundamental points in the treatment of eclampsia was to avoid any source of reflex irritation, and he, therefore, considered it bad practice to try to induce labour by bougies in eclampsia. Whether it was *post hoc* or *propter hoc*, the patient whose case he was discussing had her first eclamptic seizure some hours after the introduction of the bougies. He agreed with Dr. Smith in deprecating the use of the expression mixed accidental hæmorrhage, inasmuch as there was no form which was altogether external, and internal hæmorrhage was the only form which might not be mixed. Coming to the three cases of inversion of the uterus, it was a curious fact that when any rare case occurred they got three of them. That was a well-known rule in hospitals. There were also three cases of embolism in this Report. The indications for the forceps should be danger to the mother or danger to the child. When he was Master of the Rotunda he determined to follow that rule, and the result was that he had only twenty forceps cases in the house. If this rule was still followed, he asked why there were forty forceps cases one year and only twenty another year? The forceps had been applied in six cases of pelvic deformity. The interesting point was to know whether they had been put on before the head had passed the brim or afterwards, but this was not stated. All through the Report he found little imperfections which seemed to show that it had been carelessly put together. At the top of page 6, in the case of a woman who had died of convulsions, the left lobe of the liver was said to have shown microscopically the usual patches of hæmorrhage, having no connection with any vascular system. He had never heard of "hæmorrhage having no connection with any vascular system." There were five or six cases of deaths which were attributable to ignorant midwifery, and it was a terrible thing to think that, in the City of Dublin, with three large maternity hospitals, and Sir Patrick Dun's Extern Maternity, where nurses were properly trained, lives should be lost through the attendance of absolutely ignorant women.

Dr. KINN said that they need not pay attention to the clerical errors appearing in the Report. Referring to the treatment of complete inversion of the uterus, he thought that the rule taught in Dublin and elsewhere was that they should replace, first, those parts which came down last, and not to press upon the centre of the fundus that had been prolapsed. It was stated in a case of rupture of the uterus that strips of iodoform gauze ten yards long were passed through the rent in the uterus into the abdominal cavity. This seemed to him an extraordinary length, but perhaps it was a clerical error.

Dr. JELLETT, speaking of the treatment of abortions, remarked the number of cases in the house that were curetted was nearly 50 per cent. Though he could not say that the curetting had led to any bad results, he thought they would do harm if they sent out men with

the idea that 50 per cent. of abortions required curetting. The same idea had occurred to him as to others regarding the term mixed hæmorrhage, but certain German writers divided accidental hæmorrhage into concealed, external, and mixed, the last meaning cases in which there was sufficient of both concealed and of external hæmorrhage. In a case of funis presentation, the child was perforated, because version could not be done owing to the indications of threatened rupture. After perforation the woman was allowed to lie for several hours to deliver herself, and he asked what was the reason for this new departure in Rotunda treatment.

Dr. TWEEDY, referred to a case of hæmatoma on page 8, described as a very rare condition, said it appeared to him that hæmatoma of the cervix was a condition that occurred before the os was fully opened, and before the presenting part had passed through the cervix. Winckel mentioned it as one of the causes of decrease in size of the os. He did not think that this condition of large anterior lip of the cervix protruding through the vulva came under the head of hæmatoma, but if it did, he thought it the commonest of all accidents.

Dr. MACAN said that, though the mortality and morbidity results were very good, he agreed that most of the cases had been reported in such a way as to leave the important points out. As far as the external department went, he joined in the chorus against sending men out, believing that 47 per cent. or so of abortion cases required curetting. He did not know how an old cervical laceration, unless there was extensive erosion, could cause post-partum hæmorrhage. Speaking of the treatment of accidental hæmorrhage, he could not say that plugging the uterus or vagina was at all a good treatment, for if the membranes were ruptured, and they plugged, they only made an external hæmorrhage internal. He commended the term mixed hæmorrhage, because they might have not only an external and an internal hæmorrhage, but also a slight external hæmorrhage with marked symptoms of internal hæmorrhage, which might then be termed mixed. As regards the cases of pelvic deformity, there should have been more definite data given as to the nature of the deformity in each case.

Dr. PUREFOR said that owing to the advanced hour of the evening he would like to defer his reply until the next meeting of the Section.

The Section then adjourned.

OBSTETRICAL SOCIETY.

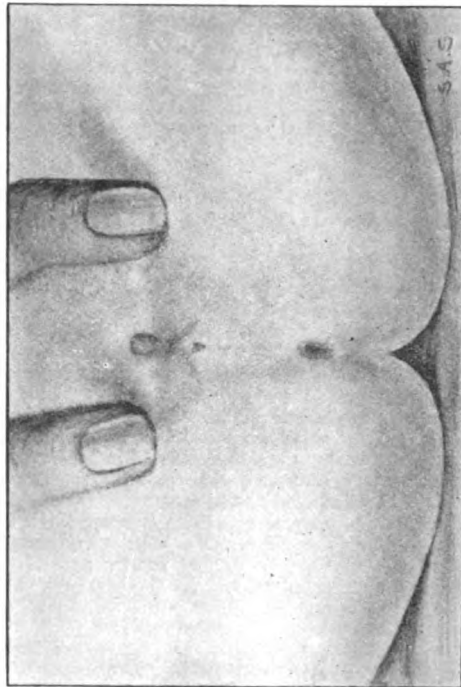
MEETING HELD WEDNESDAY, MARCH 7TH, 1900.

Dr. ALBAN DORAN, President, in the Chair,

Dr. MACNAUGHTON-JONES brought forward the following cases: (1) Congenital malformation of the genital organs, in a child three years of age—absence of the internal genitals, atresia of the vagina and rudimentary external genitalia. The entrance to the vagina was completely closed, and there were no labia. A small orifice led to a normal urethra. The outlet was entirely obstructed by integument. On incising this, to the depth of about a quarter of an inch, a rudimentary canal was discovered, large enough to admit the little finger, and at its upper end was a small nodule which represented the cervix uteri. On examining through the rectum for the uterus, bi-manually, and with a dilator in the bladder, an imperfectly developed one could be felt about three-quarters of an inch in length, and a centimetre in width, but there was no vestige of adnexa at either side. This was verified by a most careful examination. The vaginal opening was enlarged by a backward incision, and the lower portion of the mucous membrane of the small vaginal canal was freed, and brought down and fixed at the outlet. The cosmetic effect has been excellent.

Case 2.—Congenital absence of the internal genitalia. Patient was 24 years of age. She had never menstruated. There was but little hair on the external genitalia, which were normal, as were also the vaginal orifice and the vagina. The only evidence of uterus that could be detected was a small knob-like substance in the roof of

the vagina about the size of a small marble. Most careful examination made as in the last case, under deep anæsthesia, failed to detect any vestige of tube or ovary at either side. The mammary glands were like those of a male, and quite rudimentary. It had been noticed that as a girl the patient had never shown any appreciation, but rather the reverse, of advances made to her by the opposite sex.



ABSENCE OF THE INTERNAL GENITALIA IN A WOMAN 24 YEARS OF AGE—RUDIMENTARY MAMMARY GLANDS.

Dr. CULLINGWORTH, conjointly with Dr. Fairbairn, showed a specimen removed from a married woman, æt. 51, admitted on February 20th. Had had several children, and had ceased to menstruate three years previously. Eight years ago she suffered from hæmorrhage for fourteen weeks. Just before her last pregnancy, eighteen years ago, she had a sharp pain in the left side, which, however, passed off in a few hours, and pregnancy ran a normal course. The pain had remained more or less ever since. She said the abdomen had been increasing in size for some years. On January 21st, 1900, after a severe bout of pain in the abdomen, and since then she had felt ill and had lost flesh. On examination a large, fluctuating, somewhat movable tumour was felt, occupying the abdomen, part of it extending into the pelvis. The uterus appeared to be normal. Abdominal section was performed on February 22nd, when the tumour was found to be adherent to the abdominal wall as well as to intestine and omentum. It was tapped, and nearly five pints of pea-soup-like, inodorous fluid withdrawn. This was opaque, viscid, and of a greenish-yellow colour. The adhesions having been separated and the pedicle (which was connected with the left appendages) transfixed, it was seen that the under surface, below a matted mass of bowel and omentum, was a smooth bed of thickened peritoneum. The right appendages were fairly normal, the ovary, however, containing a small cyst which ruptured during the operation. The cyst, collapsed and empty, measured 7 ins. by 7 ins. Its outer covering was peritoneum beneath which was a thick white fibrous capsule. The whole under external surface was covered with a thick layer of white inflammatory lymph. The portion of Fallopian tube removed measured 4 ins. in length, and it was slightly dilated up to the part where it opened into the cyst. The aperture of communication was large enough to admit the finger and the lining of the tube appeared to be continuous with that of the cyst. The interest of the case lay in its protracted history; the absence of any history of definite illness between the first attack and the last; and, lastly, the real character of the specimen, i.e.,

whether a tubo-ovarian cyst or an enormously dilated Fallopian tube simulating it.

Dr. FAIRBAIN said the point about the cyst was that for about four inches the tube was very inflamed, and it opened directly into the interior of the cyst, the lining of the latter being continuous with that of the tube. It contained 4½ pints of greenish fluid with flakes of lymph. The tube itself was much thickened and was full of inflammatory *débris*. He discussed the question whether the cyst was a dilated portion of the tube or an ovarian cyst. He pointed out that the cyst wall had grown into the layers of the mesosalpinx and no ovary was to be seen. It, too, was large, measuring 7 by 7 inches. Microscopical sections simply showed granulation tissue on the outside, there being no trace of muscular tissue.

The PRESIDENT said they were not all convinced that the lower part was not tubal. By the time the disease reached this stage the question of origin became obscure.

The specimen was ultimately referred to a special committee for examination and report.

DROPSICAL PARASITIC FŒTUSES.

Mr. ARTHUR KEITH, introduced by Dr. LEWERS, gave a lantern demonstration on the anatomy of two specimens of dropsical parasitic fœtuses. One, given to him for examination by Dr. Lewers, was at full time, the other was in the fifth month. In both the circulation was carried on by the host fœtus, each fœtus being one of twins. Each fœtus was therefore of the nature of a bud, the parasite being supplied with impure blood from the host. In both specimens the hinder extremities and the caudal end of the body were better developed than the anterior extremities and cephalic ends. The principal interest in these specimens lay in the fact that they reproduced the lesions which many observers had experimentally produced in chick embryos hatched under abnormal conditions of temperature and position. Such chicks showed (1) dropsical conditions of the tissues and closed cavities, especially a dropsy of the central nervous canal; (2) malformations of the blood islands and primary blood vessels; and (3) abnormal segmentation of the trunk. Such lesions appeared in the two specimens, and probably as early as the fifteenth day. In the younger of the two segmentation forwards had been arrested at the seventh cervical segment, the central nervous system in front of that point being absent. The foregut was also absent, but the glands and structures derived from that part or the gut, the heart, nodules of bones representing the mandible, hyoid, and base of the skull, and three processes representing the fronto-nasal and lateral maxillary processes were present. In the larger specimen anterior segmentation was arrested in the frontal region, the frontal-nasal and maxillary processes being present, with the cerebral vesicle and central nervous tube, which was so dilated that it had burst the skull apart, and carried with it the separated bones on the one side and the shoulder-girdle on the other. The foregut was present, with the lung buds and a small, functionless three-chambered heart. In the smaller fœtus segmentation had proceeded backwards to the third coccygeal segment, leading to a normal development of the hindgut and its derivatives. In the larger specimen segmentation was arrested at the first lumbar vertebra, with a result that the hind-limb buds were left in close contact, a symmelian extremity resulting. Many ribs and vertebrae were imperfectly separated. The hindgut ended blindly, and there were no external genitals. The blood in the umbilical vein showed more leucocytes than red blood discs. The subcutaneous tissue was mucoid, there were no structural differences between arteries and veins, and nucleated corpuscles, some containing hæmoglobin, were found in the bone marrow. In both specimens the thyroid, spleen, thymus, and liver were absent. In the large fœtus ovaries and rudimentary kidneys were present, and in the smaller fœtus the genito-urinary arrangements of a fifth-month fœtus were noticeable. These dropsical parasitic fœtuses were probably the result of an imperfect division of the ovum to form twins. It was known experimentally that absorption of part of a segmenting ovum led to such

errors in development. A parasitic fœtus was probably the result of the unequal division of a twin-forming ovum.

Dr. BOXALL referred to a similar case of his own, similar, however, only in respect of the general cedema of the fœtus, for in other respects he doubted whether it was on a par with the author's case. His was a seven months' fœtus, and with it there was a very large placenta. It was at present nothing like what it was at birth, some forty ounces having drained away in the course of a few hours. The surface of the body, especially the face and scalp, were covered with a papular eruption. The mother had been in very bad health, and died a few hours after the delivery from some unknown cause. No history of syphilis. He looked upon a very large placenta as in some sort compensatory to a difficulty of fetal circulation. The kidneys were quite healthy. He quite anticipated that they would find something wrong with the heart or the large vessels. The fœtus when grasped felt like a juicy pear, and a leg came away in his hand.

Mr. KEITH, in reply, said he looked upon it as a blood disease, and not as a disease of maternal origin.

The PRESIDENT said he had published a communication on acardiac monsters in the museums of the London medical schools, which was to be found in the Society's "Transactions" for 1889. He congratulated Mr. Keith on his lucid demonstration of a very complicated teratological subject. Dr. Boxall's and Mr. Keith's two specimens suggested reflections on the precise significance of fetal cedema and anasarca.

EXTRAUTERINE GESTATION.

Dr. JOHN PHILLIPS read a paper on a case of extra-uterine gestation in which fetal death occurred at term after spurious labour, and where abdominal section was performed four or five months later. The patient, æt. 31, with three children, the youngest nine years of age, menstruated last normally in November, 1896, the exact date being uncertain. About a month later she was seized with severe abdominal pain, and was ill for fourteen days. Subsequently all the symptoms of a normal pregnancy developed; she had, however, frequent and prolonged attacks of pelvic and abdominal pain. At term a spurious labour occurred, and subsequently the signs of pregnancy became less marked, and the abdomen less distended. From four to five months afterwards she was seized with much pain and fever after a rigor. The abdomen was opened, and a full-term dead fœtus removed from an extrauterine sac. The placenta, which was putrid, was removed without hæmorrhage. The patient made a good recovery, and was now in good health.

Dr. CULLINGWORTH recalled that, as tending to corroborate Mr. Bland Sutton's observations on the analogy between the behaviour of the uterus and the Fallopian tubes when expelling a contained ovum, he had on a previous occasion exhibited to the Society a Fallopian tube which had entirely resumed its normal appearance ten hours after the occurrence of rupture and expulsion of an early ovum. He approved the author's theory that there had been a complete tubal abortion, and that the ovum had preserved its vitality, and had continued to develop in the abdominal cavity. The fetal sac would then, he supposed, be the fetal membranes, and asked if it had been examined. He asked for further details as to the site of implantation of the placenta, especially whether the placenta had retained its connection, wholly or in part, with its original site, which was the general rule.

The PRESIDENT observed that his own case of removal of putrid fœtus would shortly be reported. It was not "abdominal" but of the "posterior ligamentary" type, infection occurring through the walls of the rectum. The patient did well for six weeks, and then sank slowly from marasmus rather than complete obstruction, dying in the ninth week. He asked Dr. Phillips whence the putrid infection was derived in his case.

Dr. JOHN PHILLIPS, in reply, said that a piece of the sac wall had been excised and microscopically examined, and consisted of fibrous tissue. The colon was incorporated in the sac walls, thus giving rise to the putrefactive changes.

BRITISH LARYNGOLOGICAL, RHINOLOGICAL,
AND OTOLOGICAL ASSOCIATION.

GENERAL MEETING HELD FRIDAY, MARCH 9TH, 1900.

The President, DR. BARCLAY BARON, in the Chair.

THE PRESIDENT alluded with regret to the loss which the Association had sustained in the death of Dr. McNeill Whistler, one of the founders and a former President of the Society. A vote of condolence with Mrs. Whistler was unanimously carried.

MR. MAYO COLLIER showed a case of Abductor Paralysis of the Left Vocal Cord in a young woman, the cause of which was undetermined.

CONDITIONS OF THE THROAT AND LARYNX SIMULATING
AND PREDISPOSING TO TUBERCULOSIS.

The discussion was opened by MR. LENNOX BROWNE with the statement that although it does not so frequently fall to the lot of the laryngologist to decide doubts as to the tuberculous, non-tuberculous or pre-tuberculous condition of a throat or larynx as is the case with physicians devoting themselves to diseases of the chest, the responsibility is no lighter nor is the issue less vital. It is, however, a fact, that occasionally the prodromata of a tuberculosis can be discerned with the laryngeal mirror before the ear can detect it with the stethoscope. In such circumstances it is possible to arrest the disease in the higher situation. Dismissing shortly instances of simple inflammations, of syphilis, and of lupus in the larynx which might be mistaken for tuberculosis, attention was drawn to the influence of nasal obstruction and faucial irritation in bringing about conditions not only liable to be mistaken for tuberculosis, but as distinctly forerunners of that disease. Many cases were reported showing that there are no definite laryngeal evidences which can be accepted as criteria of a tuberculous condition or tendency thereto, and the same might be said with regard to physical signs in the chest and even of the bacteriological features; for one case was related of a patient in whom, with a history of hæmoptysis, want of resonance, moist râles and old adhesions, together with the presence of bacilli, complete recovery of health took place after efficient treatment of faucial irritation. In this case an eminent physician, without committing himself to the statement that the patient was free from the danger of tuberculous trouble was of opinion that "looking at the progress of the case the consolidation had been mainly of a broncho-pneumonic nature set up by the violent cough from which the patient had suffered, and which had been so remarkably checked" by faucial and laryngeal treatment. The indications for treatment of the class of case considered were:—1. To clear away all obstruction to free nasal respiration. 2. To remove all source of irritation in the palate and fauces. 3. To correct the products of catarrh by suitable intra-laryngeal treatment. The author preferred sprays of guaiacol diluted 50 per cent. with almond oil carried deeply in the larynx and trachea under pressure. 4. While recognising the value of the open-air treatment he thought a warning was due not to surrender entirely, as there was a tendency to do attack of the disease by drugs, and especially where as was the case in the throat, the site of infection was well within reach.

DR. FROBOWOOD observed that prominence of the arytenoids and infiltration of the commissure were valuable indications of pulmonary tuberculosis, with which disease also an anæmic condition of the pharynx and laryngeal region was often associated.

DR. J. MACINTYRE (Glasgow) expressed his belief in a pre-tubercular condition in the larynx, before a bacillary diagnosis can be made.

MR. MAYO COLLIER spoke of the increasing rarity of tubercular affections the higher one ascends the respiratory tract.

MR. ST. GEORGE REID discussed the significance of micro-organisms in sputa, notably the micrococcus tetragenus as a possible forerunner of tubercle bacilli.

DR. DUNDAS GRANT spoke of cases which simulate tuberculosis.

The discussion was continued by Dr. Foster Palmer, Dr. P. Abercrombie, Mr. Wyatt Wingrave, and the President. Mr. Lennox-Browne replied.

SHEFFIELD MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD THURSDAY, MARCH 1ST, 1900.

Dr. BURGESS, President, in the Chair.

DR. PORTER showed cases of aortic stenosis and mitral stenosis.

DR. SORLEY showed a case of club-foot associated with spinal lesion.

DR. DYSON showed two cases of Grave's disease. One had been under his observation eight years and the other twelve years. In one case the tendency to exacerbations and the value of rest in bed and the administration of thymus tablets were mentioned. The other case was particularly interesting, in that the thyroid gland was completely atrophied. The pulse had gradually sunk from 140 to 60, and the proptosis was less. He made remarks on the prognosis of the disease, especially referring to the modes of death and the relation of the disease to the physiology of the sexual system.

MR. DALE-JAMES showed a case of lichen-scrupulorum in a child of 16 months. The initial lesion was very characteristic, but the distribution was uncommon and very general. The case was interesting chiefly because of the age, distribution, and rarity in this district.

Dr. GILES read a paper on a case of

SIMPLE TONSILLITIS WITH PARALYSIS.

G. K., æt. 18, was taken suddenly ill on January 21st with pains all over and sore throat. When seen the temperature was 102.4 degs. The fauces and tonsils were much reddened and swollen, especially the right. The cervical glands were somewhat enlarged; there was no albumen in the urine. A bacteriological examination showed no diphtheria bacilli. He improved rapidly up to January 29th, when he was again taken much worse. Both tonsils were again swollen with the peritonsillar tissues. The cervical glands were enlarged. All fluids came through the nose. There were no other paralytic signs. On examination no diphtheria bacilli were found. In three days this passed off. He considered the paralysis to have been due to mechanical interference with the movements of the palate, and that diphtheria may fairly be eliminated.

DR. ARTHUR HALL read a paper on "Some Unusual Cases of Skin Disease," illustrated by patients, drawings, &c., which will be found under "Clinical Records."

EDINBURGH MEDICO-CHIRURGICAL SOCIETY

MEETING HELD WEDNESDAY, MARCH 7TH, 1900.

Mr. A. G. MILLAR, President, in the Chair.

THE INFLUENCE OF HEREDITY IN DISEASE.

PROFESSOR HAMILTON, of Aberdeen, read a paper on this subject, an abstract of which we publish on page 291.

DR. CLOUSTON instanced one of the royal houses of Europe as a case in which the psychopathic constitution had been transmitted through generations for 200 years. He believed that most neuroses were due to an alteration in the developmental power of the nerve cells—to some failure in their maturation. Most of the neuroses occurred during the developmental period, and then again during the period of natural decay. The hereditary defect was simply a tendency to a delay or arrest of the proper development of the nerve cells. He also alluded to the hereditary alcoholic habit as being partly the result of an acquired character, and partly the result of the neurotic constitution.

DR. JOSEPH BELL spoke of the very marked tendency certain families show to the development of wens and congenital abnormalities such as polydactyly.

Professor COSSAR EWART said that the view that acquired characters—and under this name he included diseases—were transmissible was one which unfortu-

nately still obtained among medical men, but which had done more to hinder the progress of biology than almost any other doctrine. It had now been given up by all biologists. The views of Professor Hamilton were quite orthodox from the biologist's point of view. He did not, however, think that it was necessary to suppose that the tendency to tuberculosis, to gout, or to nervous disease had been transmitted through countless generations from some early variation in the germ plasm. It was well known that while animals which were left to themselves remained very constant, if breeds or strains were mingled what might be called an epidemic of variations arose. Such intermingling and crossing constantly occurred in mankind, and was all that was necessary to account for the frequent recurrence of these disease tendencies. All his recent work went to show that the germ plasm was exceedingly sensitive. He also thought that reversion played a more important part than was generally believed in the production of variations.

Dr. BALLANTYNE referred to the extreme improbability of the effect of maternal impressions. He thought that it was very difficult to draw a hard and fast line between infectious disease of the fetus and hereditary malformations, such as those due to lead, alcohol, &c.

Professor STEWART STOCKMAN said that as a veterinary student he had been taught to recognise cattle as predisposed to tubercle; since the introduction of the tuberculin test it had been proved that all such animals were not only predisposed to tubercle, but already actually tuberculous. Might it not be so also in man? Congenital tuberculosis was excessively rare in cattle; during the last four years, out of eight thousand animals slaughtered annually there was only one case.

Dr. JAMES favoured the idea that acquired characters were transmitted. He thought that when an individual had acquired immunity against one of the infectious diseases, this peculiarity was transmitted to his descendants.

Professor SCHAFER said that Romanes had made some experiments on guinea-pigs which tended to disprove Brown-Sequard's contention that an acquired neurosis could be transmitted.

Professor Hamilton replied.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, March 17th, 1900.

INFLUENZA.

At the Academy of Medicine, M. Femel said that influenza was a toxi-infectious malady, contagious and specially characterised by nervous disturbance, fever and visceral congestion. The bacillus of Pfeiffer was the primary cause, but the toxins furnished by that bacillus determined the greater part of the accidents. He esteemed consequently that the prophylaxis of the gripe consisted in isolating the patients when practicable, and in the antisepsy of the nose and the mouth by which ordinarily the germs of infection find an entry. Until a specific remedy was found, the therapeutic indications of the gripe were those of other toxi-infectious maladies, and consisted in nourishing the patient as much as possible so as to give him the necessary strength to resist the disease, and to encourage the elimination of the hurtful elements by different emunctories, and particularly by the kidneys. Milk and diuretics of the simplest kind appeared to him to fulfil better than other treatment those indications. If the absorption of liquids by the stomach presented some difficulties, enemas of milk or Vichy water and milk or subcutaneous injections of salted

water might replace them. When the fever ran high it should be treated with cold lotions, the wet sheet or even with cold baths. As to the visceral congestions, and especially pulmonary congestions, which appeared to depend on paresis of the pneumogastric nerve, and which were accompanied by tachycardia of the same origin, he knew of no better remedy than the cold compress applied to the affected region, or the enveloping of the thorax during half a minute with a towel steeped in cold water. These applications might be renewed every one or two hours.

As to quinine, antipyrine, &c., he did not consider them of much value, on the other hand, subcutaneous injections of a solution of strychnine had given him certain good results.

M. Mignot thought the subdural condition of the digestive tract should be treated with calomel in fractional doses. If the cough persisted and was accompanied with signs of pulmonary congestion a blister should be prescribed.

The temperature of the sick room should be maintained at 68 degs. Fahr.

FOREIGN BODIES IN THE TRACHEA.

M. Vignard related two cases of foreign bodies in the trachea treated by tracheotomy. The first was that of a child of two-and-a-half, who, playing with some whole coffee, was suddenly seized with a violent access of suffocation. After a few minutes he became calmer, but during the night several fits came on. The mother was greatly frightened, and brought the child the next day to a country doctor, saying that she feared the patient had swallowed "the wrong way" a coffee berry. The idea was not admitted by the physician, who prescribed for bronchitis. However, the condition of the child grew worse, the fits of suffocation became more frequent, and the gravest symptoms set in. On the seventh day after the accident the patient was seen by another *confrere*, who concluded on the presence of a foreign body in the trachea, and advised the mother to bring it to the hospital without delay. When M. Vignard saw the child he was relatively calm, but it was noticed that he breathed with some difficulty, and the lips were somewhat cyanosed. The most attentive examination, however, could not reveal anything abnormal, neither in the trachea nor in the bronchi. Having learned the history of the case, M. Vignard decided on accepting the mother's version of the cause of the trouble and performed tracheotomy, and when the lips of the wound were well drawn aside, something black could be seen lying at the bottom of the trachea. A forceps was passed in, and drew out a large grain of coffee.

The second case was that of a child of four who swallowed a French bean. Doctors were called in, but refused to take upon themselves the responsibility of an operation. When M. Vignard saw the boy, he was already dying; he performed tracheotomy, however, but the child had not the strength to expel the foreign body and succumbed in a few minutes.

In concluding, M. Vignard said that in all such cases tracheotomy should be performed as soon as possible, as delay was dangerous. He knew that that advice contrasted with that of Prof. Tillaux, who pronounced for retarding the operation until every other means were tried.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, March 17th, 1900.

At the Free Society of Surgeons, Hr. Fritz König gave a note on

POLYPOSIS RECTI.

In Prof. v. Bergmann's Klinik, a woman was operated on in 1890 for multiple papilloma of the rectum. She had been perfectly well from that time until the autumn of 1899, and from then she suffered from pains in the rectum, and frequent mucous discharges, but no blood. She returned to the klinik in December, and then had a tumour 5 cm. above the anus, and seated on the posterior wall of the rectum. Operation was performed, but as the sacrum was sawn through and the rectum opened, numerous polypi were found on the rectal walls extending as far up the bowel as could be reached.

The tumour that was removed proved to be a pure adenoma, not a carcinoma. It was remarkable that the tumour, which must have been present a long time, only gave rise to symptoms three months ago.

Hr. Rotter had reported a case a year and a half ago of inoperable malignant adenoma of the rectum that had been scraped repeatedly but had always returned. One day, however, when the patient had been out of hospital a long time, contrary to expectation, it was found to be healed. After a year and a half the patient came back again with metastatic glandular growths over the right ilium and soon died of cachexia.

At the section polyposis was found extending high up in the colon, the polypi reaching the size of a walnut, and in places growing thickly together. They were all of benign character, the metastatic tumour must therefore have originated in the malignant adenoma, the site of which had completely cicatrized over for more than a year.

At the Free Society of Surgeons, Hr. Rotter read a paper on

THE PATHOLOGY AND THERAPEUTICS OF ABSCESSSES OF DOUGLAS'S POUCH IN PERITYPHLITIS.

He said that during the past four years 454 cases of perityphlitis had been admitted into St. Hedwig's Hospital, 83 during free intervals, 371 during acute attacks. Of the latter class with abscesses, 132 had been operated on. The abscesses could be classed as follows: 83 on the right ilium, 41 in Douglas's pouch, 13 in the right lumbar region, 9 above Poupart's ligament on the left, and 4 subphrenic.

Of the 41 abscesses in Douglas's pouch, 21 were solitary. In fourteen cases the abscess ran forwards over the symphysis, the remaining seven were not to be felt from the outside.

It was not at all necessary that the vermiform process should be in Douglas's pouch for an abscess to form there on its becoming perforated. The appendix became perforated wherever it might be lying in the free abdomen, the pus there falling into the lowest part, or serous exudation took place here first, which became infected secondarily, giving rise to suppuration.

Diagnostically the marked distention of the abdomen was important, as it remained after the other symptoms of peritonitis had subsided. This was caused by compression of the colon. In two cases the chief trouble lay in violent tenesmus and mucous stools, just as if the case were one of proctitis.

The diagnosis was easy when one was in the habit of examining all cases of perityphlitis and peritonitis by the rectum; otherwise such an abscess could easily escape notice. If there were any doubt as to whether a collection contained pus, an exploratory puncture could easily be made from the rectum and without danger.

If in addition to the abscess in Douglas's pouch there was one on the ilium, if the division wall were thin and the operator did not fear to push through into the general peritoneum, it was easy to break through and drain the one through the other. This procedure was, however, not free from danger. In opening from above there was a disadvantage in opening at the highest point of the abscess. In women one generally opened from the posterior vaginal wall. In males one could open through the perineum, but the procedure was not simple, required narcosis, and was sometimes very bloody; the way was long, at least in fat people, and injuries could easily be inflicted unintentionally.

On the other hand opening from the rectum was very simple, did not require an anæsthetic, and was free from danger. After preliminary puncture, the abscess was opened bluntly, i.e., with blunt instruments, and it was not necessary to drain. Without any dressings the patient was put to bed, lying there until the cavity was closed. According to the speaker's experience there was no danger of fecal matter entering the abscess cavity. He had emptied nine abscesses from the anterior abdominal wall, three patients died. He had opened thirty-five from below, nine from the vagina in women, with one death from phlegmon of the pelvic connective tissue eleven from the perineum, with one death from peritonitis, and fifteen from the rectum, all these recovering. It was a question whether the opening should not be made from the rectum in women also as the os and cervix uteri would be spared thereby any contact with purulent material.

The same speaker then gave a short note on

INFLAMMATORY STRICTURES OF THE SIGMOID FLEXURE.

He had seen four cases of stricture of the sigmoid flexure—one in a woman, three in men. All four presented symptoms of ileus, of which, as they came under observation too late for treatment, they all died. The seat of the disease was the subserous tissue; here suppuration had become established. One from attachment of the perforated vermiform appendix to the bowel, one from so-called false diverticula of the mucous membrane. Fistulous passages were established around the intestines, which had caused contraction of the connective tissue, and led to stenoses, which in both instances led to an appearance of a tumour. It seemed as if this was a favourite mode of origin for strictures of the sigmoid flexure.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, March 17th, 1900.

OTITIS WITH INTRACRANICAL COMPLICATIONS.

At the "Medical Club" Hammerschlag exhibited three cases of otitis, with intracranial complications that made excellent recoveries after operation.

The first was a young woman, æt. 20, who took ill on January 17th with severe pain in the left side of the head. On the 20th rigors commenced, which repeated

themselves daily at regular intervals. After a short time the ear began to discharge, destroying the tympanum; the external ear being wide and open, while the soft tissues over the mastoid were normal. The tuning fork pronounced the process to be otitis media uncomplicated.

The day after this minute examination it was resolved to open the middle ear, which was laid open from the cavum tympani to the cavernous sinus, where a little perisinous pus was found. The sigmoid sinus was left intact. Next evening another rigor occurred, which led to another operation and the slitting of the sinus. After this all the morbid phenomena disappeared, and perfect recovery resulted. This case demonstrates how misleading symptoms are in the presence of grave complications.

The second case was a girl, *æt.* 7, who took ill in April, 1899, with pain in the ear. In the autumn polypi were removed; but on February 11th of the present year vomiting and severe pain in right ear suddenly commenced with fever and pain in the neck. The temperature rose to 38.5 degs. Cent., or 102.02 Fahr., while the mind was perfectly clear, though the symptoms pointed directly to meningitis. Operation laid the middle ear and cavernous sinus open, and revealed a discoloured condition of the dura mater, which contained pus that was cleared out. Two days after this the temperature fell, and all the meningeal symptoms disappeared. Here it would seem that a local circumscribed meningitis was present which was checked and cured by the early operation.

The third case was a female also, *æt.* 17, who had suffered from ear disease since she was five years of age, with purulent discharges off and on. In October last year severe pain commenced in the right ear; on the 26th of the same month she entered the "Clinic" in apparently good health, but by ten o'clock in the morning she was seized with agonising pain, vomiting, strabismus, suddenly followed by unconsciousness.

About mid-day she was operated on, when the middle ear was found filled with stinking pus; the dura mater of the middle sinus was found healthy, but the posterior sinus was found discoloured. The dura mater was slit at different points, and the cerebellum punctured, but no abscess was to be discovered. Immediately after the operation beneficial effects were observed, and three hours later consciousness returned. Next day she was better, and the wound soon healed up.

This resembles the preceding case where prompt intervention saved life by limiting the meningitis.

LESION OF THE CONUS MEDULLÆ SPINALIS.

Kienböck next showed a male patient, *æt.* 45, who two years ago fell from a height on his buttocks. He never was unconscious, but was lame for some time after, from which he recovered in two months, being able to walk about as before. On the other hand, the bowel and urine lesion remained irreparable. From the time of the injury the catheter had to be used, and the bladder irrigated; at present incontinence exists. The bowels have to be cleared out by injections; "cold paræsthesia" is present over the buttocks, perineum, and on inner side of the upper part of the leg. Between the first and second lumbar vertebræ there is space which indicates a fracture of the spinal cord which seems to be confined to the conus medullæ spinalis as the symptoms are against a caudal lesion as the symmetry, absence of

irritation phenomena and a gradual reduction of the sensation in the surroundings. No hope of further improvement can be anticipated, neither is it likely to grow worse.

The Operating Theatres.

KING'S COLLEGE HOSPITAL.

REMOVAL OF THE SUPERIOR AND MIDDLE CERVICAL GANGLIA OF THE SYMPATHETIC FOR MYXO-FIBROMA.—Mr. BURGHARD operated on a man, *æt.* 35, who had been suffering for two years from what was apparently enlarged glands in the neck, accompanied by excruciating pain, extending from the neck to over the region of the great occipital nerve and the descending branches of the superficial cervical plexus. The pain was so great as to prevent the patient doing his work, and necessitated the constant use of morphia. On examination the patient, who was a somewhat anæmic-looking man, had what appeared to be a single enlarged gland about the size of a walnut, very soft, but not fluctuating in the anterior triangle on the right side just above the bifurcation of the carotid. There was considerable tenderness on pressure. Along the course of the great occipital nerve was a series of small somewhat soft swellings running along the whole length of the nerve at intervals of about a quarter of an inch. There were no eye symptoms. Mr. Burghard said he at first thought it was not a case of ordinary tuberculous glands, because of the peculiar distribution of the swellings along the occipital nerve, and because of the intense pain. Although he was inclined to think the disease might be malignant owing to the distribution of the mischief which infected the deep branches of the cervical plexus, he determined to attempt to remove the main mass in the neck, in order at least to relieve the intense pain, which was entirely incapacitating the patient. The man having been anaesthetised, an incision was made similar to that for tying the internal carotid, that is to say parallel with, and just over, the anterior border of the sterno-mastoid from the middle of the thyroid cartilage to nearly opposite the angle of the jaw. After the fascia had been opened up, it was seen that the tumour, which was extremely soft and compressible, bulged forwards from behind the internal carotid and the jugular vein, separating these structures and protruding between them. The vessels were carefully separated and pulled apart by retractors, the vagus being seen and carefully retracted along with the artery. The tumour was then exposed as an ovoid structure about three inches in its vertical diameter, and one-and-a-half inch transversely, and considerably flattened from before backwards, lying upon the Longus colli muscle and the transverse processes of the second and third cervical vertebræ. As the tumour was cleared, a stout cord prolonging it downwards was defined, and this was traced down to another tumour about the size of a hazel nut similar in character to the first. From the upper tumour a series of filaments were found passing forwards, backwards, and upwards, corresponding with the connecting branches of the superior ganglion of the cervical sympathetic; it soon became evident that the upper tumour was the ganglion itself, whilst the lower was the middle cervical ganglion. No differentiation could be made between the ganglion and the tumour, the swelling appeared to be a uniform enlargement of

the ganglion in all directions. The two tumours (superior and middle ganglia) were therefore isolated and removed after their connections had been divided with scissors. The effect of the removal on the pulse and eye was noted: the former showed hardly any alteration; it remained perfectly regular, and was, if anything, slightly slower than before; the pupil of the same side contracted very markedly, and remained so during the rest of the operation. There was no alteration in the intra-ocular tension; slight ptosis was noticed as the patient recovered from the anæsthetic. The tumour when cut into showed a mixture of gelatinous and fibrous structure, and a thin mucous fluid oozed from the cut surface. Mr. Burghard said that as far as he knew this particular condition, i.e., a tumour of the sympathetic ganglia, had not been recorded before; the growth, he pointed out, appeared as far as could be judged by the naked eye to be of a fibrous or myxomatous character, therefore it would come under the heading of the so-called neuromata; this view appeared to be still further borne out by the extension of the disease along the great occipital nerve; he proposed to delay operation on this latter until the precise nature of the tumour had been ascertained by microscopical examination. With regard to the question of ablation of the ganglion, he remarked that he had removed the superior ganglion on both sides on a former occasion a few days previously from a patient suffering from double glaucoma; the operation was quite simple and need only occupy a few minutes. The best incision is one similar to that for ligature of the internal carotid but slightly higher. The easiest way of getting at the ganglion, he said, was to expose the internal jugular vein and pull it bodily inwards when the ganglion would be found as a characteristic flattened structure behind it. In the case he referred to the ganglion on each side differed widely in size and shape, but there could be no risk in mistaking the vagus for it, the nerve, from its characteristic appearance and close relation to the back of the carotid, being easily recognised. Judging from this case, the result of removing the ganglion would probably be that while the patient would lose the pain of which he originally complained, there would in all probability be severe headache for the first two or three days, accompanied in all likelihood by dilatation of the superficial vessels of the face and of the eye on that side; there would be more or less persistent contraction of the pupil with ptosis and slight prominence of the eyeball on the affected side.

The tumour proved to be a pure fibro-myxoma. The patient's pain was so completely removed that he refused to have the remaining tumours on the occipital nerve operated on, and left the hospital with the wound healed in a fortnight. The contraction of the pupil, although not so marked as immediately after operation, was still present; there was well-marked ptosis and slight prominence of the eyeball, the pulse was normal and comparatively slow, headache was complained of for a few days after the operation, and there was little or no dilatation of the cutaneous vessels of the face.

THE Council of the Irish College of Surgeons has resolved unanimously to present to Her Majesty the Queen an address of welcome upon her arrival in Ireland.

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The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, MARCH 21, 1900.

THE FUTURE OF ASYLUM SERVICE.

FIRST ARTICLE.

IN propagating a long, if perhaps fruitless, discussion on the hours of duty of asylum attendants, the London County Council has shown evidence of an unrest and anxiety as to the future of their asylum service, which was sure to manifest itself sooner or later. In this respect the London County Council was anticipated by the Scottish Division of the Medico-Psychological Association, which has taken up the question from a broader point of view, and is going into the matter with a fulness and detail which ought to be productive of the most excellent results. The asylum service question is not merely one of hours on duty, not even a question of pay or of provision for retirement. There are a hundred and one questions great and small which confuse and complicate the subject, rendering it one of the most difficult puzzles that medical men and social reformers have to face at the present time. We have to deal with different classes in the asylum community having different aims, different interests, and different relationships; and it is possible to apparently solve the question by an increase of pay, and yet to solve it only apparently. Asylum service is admitted to be a difficult service, a trying service, and it has many drawbacks which deter people from entering it, and which—if they do enter it without sufficient knowledge—expedite their departure from it. There is no doubt that asylum service has been looked upon in the past as worse and more degrading than the lowest menial service. There was a time when a policeman was looked down upon as exercising an office worse than contemptible. If there could possibly be a degree lower it was filled in olden times, and even in recent times, by the asylum attendant or “keeper,” as he was contemptuously designated. Al

this is changed. The asylum attendant is a superior article to-day to the so-called "keeper" of thirty years ago. He is less a muscular machine, and is reckoned to have brains which can be educated and exercised, and to have manners which can be polished for the good of his unfortunate charge. If this were not so, what would have been the use and where was the sense of the Medico-Psychological Association organising a scheme of training and examination in the medical and administrative departments of his work. To-day we have evidence of the man's own self-respect being raised, his whole attitude towards patients being that of a responsible charge, as compared with the exercise of thoughtless and mechanical duties of the past. We have to take account also of the fact that the conditions of service in other spheres of employment are materially improved. It is not merely a question of pay, a question of hours, or a question of such amenities as obtained thirty years ago. It follows, therefore, that asylum attendants and nurses having themselves improved out of all recognition, and having reached a higher rung of the ladder of education, self-respect, and social ambition, naturally look for a corresponding recognition by asylum authorities, a corresponding improvement in the social, and other conditions of their existence. These facts alone should force into prominent notice, and make a question of practical politics, the future treatment of the asylum attendant and nurse. If that does not, the fact that changes are still common in asylum service, that there is continual unrest, that the average duration of residence of asylum attendants and nurses is much below what is good for the efficiency of the asylum, and the welfare of the patients contained in it should make people pause. Undoubtedly the general public know very little of the work of asylums, of the anxieties, worries, and responsibilities of the staff, but there can be no doubt of this that the humane ratepayer, and he is not quite an isolated unit, would much prefer to see the money which is freely extracted from his pocket in the name of lunacy, considerably expended, not only in the direct means of alleviation and cure of the insane, but in making the hard and irksome conditions of asylum service less hard and less irksome than they are at present in many cases. The so-called ratepayer's candidates who sometimes run our asylums do not always think so much of the patients or attendants and nurses as of the fine show that the buildings will make themselves, and they often run up a great deal of cost, which had better been spent on the real purposes of asylums. A good, solid, well arranged, comfortable asylum, carefully planned for its special needs, in the interests of the patients, and in the interests of the attendants and nurses who have charge of them is, of course, necessary, but excessive ornamentation and elaboration for purposes which do not directly or indirectly benefit the patients or officials is to be condemned. An asylum community is very much isolated, not only the insane but the sane; and in the interest of all concerned the conditions of existence for those

who are responsible for the care of the insane should be made as tolerable as possible. No average ratepayer would object to this if he knew the facts, and it will be our purpose in the following articles to make reference to several means that might be adopted to improve asylum service, to make it more attractive, and thus obtain the best possible material to make it effective.

THE ORIGIN OF MALARIA.

IN all the wonderland of scientific discovery there has been no greater marvel than that which has brought the origin and distribution of the malaria organism within the grasp of modern medicine. The story of the work that led up to the final triumph has been often told, but, like many other records that go to make history, it is one that bears repetition. The importance of a knowledge of the causation of malaria to the well-being of mankind is enormous. The strength of the British Army in India in 1897, for instance, was 178,197 men, of whom no less than 75,821 came into hospital suffering from the disease in question. During the same year no fewer than 5,026,785 persons were reported to have contracted malaria. In the face of such statistics there can be no further need to insist upon the value of any investigation that discloses fresh data upon which preventive treatment may be founded. The scientific knowledge of the etiology of malaria may be said to have commenced in 1880 with the discovery of the specific parasite by Laveran, a French army surgeon. The organism belongs not to the vegetable but the animal kingdom, and is usually known as the *Hæmatozoon malariae*, and less correctly as the *Plasmodium malariae*. The life history of this organism is of a complicated nature, and in the completion of its cycle of development it assumes various forms, which need not be described here at length. There are two, however, that have a direct bearing on the discovery of the relation of mosquitoes to the distribution of the infection, namely, the crescentic and the flagellated organisms. There has been great diversity of opinion concerning the nature of the two last-mentioned bodies, but it is now generally acknowledged that they form a kind of resting form outside the body of the organisms, of which the first stage is the flagellated condition. Manson's view was that the flagella were developed upon spores, which were taken along with blood into the body of the mosquitoes. It had been observed that certain *hæmaphysidæ* found in the blood of malarial patients threw out minute flagellant forms. The next link in the chain was contributed by Surgeon-Major Ross, another army surgeon who noticed that in the stomach of the mosquito many of the crescents become spherical, and finally develop into flagellate forms. Starting from that point Ross pursued his patient researches until he arrived at the brilliant discovery which we hope is destined to rob tropical climates of one of their greatest dangers to mankind. He argued that as the change from

crescent to flagellate forms went on both in the body of man and of insects it was probable that a suctorial insect was the means of spreading the disease. In 1895 he set to work in earnest to test the truth or otherwise of that hypothesis, but for two years and a half he was destined to disappointment, although during that period he dissected and examined many hundreds of mosquitoes. He then turned his attention from the *Culex*, which is the common kind of mosquito, to another variety, the *Anopheles*, and was rewarded by finding the parasite in the latter insect. The detection of the host rendered the rest of his task comparatively easy, for he was then able to trace the development of the malarial parasite in birds. He used larks, sparrows, pigeons, and weaver birds for the purpose of his experiments, and succeeded in infecting them all with malaria through the agency of mosquitoes. The upshot of these observations was that he ascertained definitely that not only the disease itself but the severity of the attack could be transmitted through the mosquito. Major Ross discovered the *Hæmamoebæ* *Danielewsky* in the salivary gland in the thorax of the mosquito, and it was easy to imagine that the parasite might be passed thence to the blood of a person bitten by the insect. Fortunately it is only the female insect that bites, and fortunately, again, it is not all species of mosquitoes that convey malaria. These facts narrow down the task of prevention inasmuch as they reduce enormously the number of the attacking force. The observations of Ross have been confirmed by numerous authorities, among whom may be mentioned such distinguished names as Koch, Grassi, Bignami, and Bastianelli. There can be no doubt that medical science has now secured the necessary data for the ultimate extermination of malaria. As in the case of many other scourges of mankind, future hope will lie in the direction of preventive rather than of curative measures. The natural habits of the mosquito, damp and marshy soils, will be drained or otherwise rendered unsuitable for the breeding of that pest to mankind. Already it has been shown that small quantities of paraffin will keep away mosquitoes from the stagnant waters that form their breeding-places. It is likely, also, that much greater attention will be given than formally to the exclusion of the insects from houses and sleeping-rooms, and from the bodies of persons sleeping in the open air. We may be tolerably well assured, however, that appropriate and thorough preventive measures will sooner or later follow the demonstration of the rôle played by the female *Culex* in the spread of so disastrous and widespread an infection among the human species. In some ways the unravelling of this tangled problem presents one of the most brilliant intellectual triumphs ever achieved in the annals of scientific medicine. All who have helped in the task may congratulate themselves in having aided an enterprise fraught with the highest benefits for mankind. It is worthy of note that two

of the most prominent workers have been army surgeons, one a Frenchman and the other an Englishman. That fact shows that it is possible for the lamp of pure science still to burn in the Army Medical Service, however uncongenial the surrounding atmosphere may be rendered by the chilling influences of officialism. It also proves that victories of the greatest moment may be won by non-combatants in the Army as well as by those who carry arms.

MEDICAL CHARITY.

It is probable that many of the institutions in this country which depend upon the support they receive from the donations of the charitable, will suffer more or less from the influence of the present war in South Africa. As the claims of sickness, in its various forms, predominate over all other appeals to charity, we fear that our hospitals will be the first to suffer, and for some time past their wants have rather exceeded their supplies. The views entertained by those who were the promoters of the Charity Organisation Society were chiefly concerned with the question of reforming the work carried on by hospitals, where indiscriminate relief prevailed, and was really an abuse of charity. The great system of Poor-law relief has, or ought to have provided what the hospitals did years ago. The Charity Organisation Society began by devoting more attention to hospitals than any other institutions, and how far it succeeded in reforming abuse is not very clear. When hospitals open their doors to all classes, and rejoice in advertising the numbers relieved, it is not likely that such a society as the Charity Organisation would be regarded by them with favour. The abuse of charity which prevails in hospitals is of a peculiar kind. It is somewhat of the same character as the throwing open of the doors of the church for all comers. Those who bestow charity decline to ask questions of those who accept it; though it ought to be recognised that those who give in the case of hospitals are not giving their own, but they are giving what others entrusted to them. Unfortunately, the Charity Organisation Society has been able to do so little good that we shall not be surprised if it shares the fate of some that have preceded it. There was, however, no subject to which need a society could have devoted its attention with more advantage than to that of hospital reform, and prevention of the very serious injury that was being done to the great body of the medical profession by allowing great numbers to obtain for nothing what they were perfectly able to pay for. It would be as reasonable to open bakers' and butchers' shops, and give bread and meat away to all who asked for them, as to give indiscriminate hospital treatment in the way that has prevailed and still prevails, though the Charity Organisation Society hoped to carry out its reform. The society has now to defend itself against the charge of having been guilty of an abuse of charity worse even than those abuses it undertook to correct. There is a general spirit of inquiry aroused at the present time into many matters of public interest. In daily

life we often find an indifference shown to abuses which are allowed to go on until suddenly some trouble unexpectedly comes, and then there is something done. In financial circles, in political, and in those where "charity" is concerned, there is a general feeling of inquisitiveness in order to explain the troubles which have unexpectedly arisen. Hospitals are regarded by many as necessary evils. Those upon whom their management depends are not entirely disinterested. The medical and surgical staffs look for some return from the means hospitals afford for the teaching of students, the treatment of disease, and the advantages of notoriety. How far the spirit of true charity influences this work we will not inquire. In regard to the views of subscribers to hospitals, the great employers of labour, and those who may have claims made upon them by others in whom they are interested, look to advantages from subscribing, which they can obtain in no other way. To what extent the Charity Organisation Society could reform a system in which the chief persons concerned, namely the subscribers, were not inclined to help them, we need not consider. We come back then to the question. What is charity? Charity 'vaunteth not itself, is not puffed up: doth not behave unseemly, seeketh not her own.' We believe that those who started the Charity Organisation Society were really anxious to infuse truer charity into hospital work than they saw prevailing. Let them look rather in this matter to the great body of the medical profession, among the members of which, we think, as much true charity is found as in any class or profession in this country.

Notes on Current Topics.

The Prevention of Valvular Disease in Acute Rheumatism.

No more useful subject could occupy the attention of physicians than the incidence and prevention of the cardiac complications which are so frequently associated with attacks of articular rheumatism. The more violent the attack the greater the risk of valvular mischief, and one might reasonably expect that the introduction of the salicylate treatment, by enabling us to control the pyrexial manifestations of the malady, would diminish the proportion of heart affections. This, however, does not appear to have been the case; indeed, there is reason to suspect that this treatment, by reducing the element pain, favours the very conditions which are now recognised to render patients more liable to lesions of this important viscus: that is to say, patients are apt to insist on resuming their ordinary conditions of existence long before they would otherwise have done. The outcome of the exhaustive discussion at the Clinical Society, which we published last week, goes to prove that prolonged rest is the principal factor in treatment on which confidence may be placed to reduce the proportion of heart cases. Blistering is also accorded a certain influence in warding off the endocardial inflammation, and it is worthy of note

that blistering in the neighbourhood of the inflamed joints, almost unanimously condemned by authors for many years past, seems to be coming back into favour. It should be impressed upon patients that for some months after an attack of rheumatism the heart requires rest, even in the absence of any auscultatory sign of disease. The reason for this is obvious. The disease of the valves commences with infiltration and softening of their fibrous structures, a condition which gives rise to no audible sign, so that it cannot be detected. It is not until the second stage, that of vegetations or granulations, is reached, that the physician obtains evidence of the existence of the lesion. This fact explains how it happens that a certain proportion of patients who leave hospital apparently free from any cardiac implication subsequently develop heart disease. For the same reason no person who has suffered from a recent attack of rheumatic fever can be regarded as a favourable subject from the point of view of life insurance.

A Scottish War Hospital.

THE St. Andrew's Ambulance Association has organised an excellent scheme whereby Scotland will not only provide a national hospital at the seat of war but will also add permanently to her own hospital resources in times of peace. The peculiar feature of this movement lies in the happy combination of present and future philanthropy, and its conception has been due to the energies of Mrs. George Watson, of Edinburgh, an energetic member of the Red Cross branch of the Association. Under her guidance a Ladies' League has sprung into vigorous existence. Every county in Scotland has a local branch which receives the contributions of members. There is a small money subscription, but the main feature is a monthly collection of clothing and hospital comforts, which in time of peace will be distributed yearly among the hospitals of Scotland. This scheme is simple and original, and will no doubt be well supported in a country where national feeling runs high. The Marquis of Breadalbane is president, and an influential executive has been formed in Edinburgh, with strong local committees in the counties. War hospital committees in other parts of the United Kingdom may well take the hint, and do something towards converting the present war interest into a permanent source of medical charity. Those desiring to assist the Scotch movement may learn particulars from Mrs. G. Watson, 16, South Charlotte Street, Edinburgh.

The Medical Defence Societies.

THE annual meeting of the Medical Defence Union, which was held last week, showed clearly that amalgamation between the Union and the London and Counties Medical Protection Association is further off than ever. Indeed, it would seem that the proposal has now received its quietus. While, however, the latter body have all along been favourable to the union of forces, the former have always found reason for rejecting the amalgamation;

nevertheless we should have thought that a *modus vivendi* could have been arranged by which, having regard to the various interests involved, the two societies could have agreed to act together. As a matter of fact we hear very little of the London and Counties Association, although they are doubtless doing their share of protection work; on the other hand, the Medical Defence Union is often to the fore in the law courts and in undertaking prosecutions before the General Medical Council, thus, it may be, that the older and more important body have failed to see that they would gain much, if anything, by the scheme of amalgamation.

Self-constituted Consultants.

WE commented some months since on the establishment of a wholesale corps of consultants in Birmingham who are supposed to provide expert advice for club doctors and other such practitioners at a fee of 10s. 6d. or less. We then expressed the belief that, though crowds of practitioners could be got to accept such position, no person possessing the experience worthy of a consultant would do so, or, if he did, would be respected as such by the patients. We note that a Dr. Henry Ward Irvine, of Trinity College, Dublin, has been installed in this consultative capacity, and it is just that we should say that he had so distinguished a career in Arts in the University that we are surprised that he should take up such a line of practice even with the encouragement of the "bills, pamphlets, and other information which are to be freely circulated" as an introduction for his practice. But, all the same, we apprehend that a young gentleman who qualified in 1895 can scarcely claim the title of consultant, and we are very certain that, if he does, his patients will hesitate to accord it to him.

Skin Affection in Bright's Disease.

CURIOUSLY enough the cutaneous eruptions met with in association with Bright's disease do not seem to have been very carefully studied, and Dr. Hugh Thursfield is to be congratulated on having alighted upon a subject of so much interest as the theme for his paper which was discussed at the last meeting of the Royal Medical and Chirurgical Society. An opinion is very general that the occurrence of rashes in the subject of Bright's disease justifies an unfavourable prognosis in regard to life, but although there is a certain amount of truth therein it is rather accidental than essential. Such rashes, it is pointed out, usually occur late in the course of the renal disease, and it is obvious that any symptom which occurs later on in the history of such a fatal malady must incidentally share in the gravity of the prognosis. Apart from this coincidence there does not appear to be any particular reason why cutaneous manifestations occurring in such patients should be regarded as of more importance than in other conditions. The author described four groups of cutaneous manifestations, first those of the nature of pruritus, urticaria and eczema, which are more frequent early in the disease; secondly, erythematous, bullous and des-

quamative conditions, which affect more particularly the terminal or uræmic stage of the disease, purpuric and hæmorrhagic eruptions, and, lastly, general eczema. Apart from the hæmorrhagic eruptions, which are probably due to the altered state of the blood and vessels, the eruptions are probably due to the same causes as in septicæmia, viz., the action of accumulated toxins, retained as the consequence of inadequate renal elimination. As a matter of fact, none of the eruptions are *per se* suggestive of, or peculiar to, Bright's disease, and they occur as well in the subjects of granular kidney as in other forms of renal disease. As Dr. Crocker pointed out, the same skin disease may be due to different causes in different people, or even in the same person, and its nature depends far more on constitutional peculiarities than on the determining cause.

The Finances of the Branch Medical Councils.

IT seems obvious that something definite and immediate must be done to adjust the financial arrangements of the Branch Councils upon a more equitable basis, and it is not too soon that the subject should be taken in hand by the General Medical Council, inasmuch as it is quite fifteen years since the attention of that Council was called to it. The *status quo*, as indicated by the accounts presented to the Executive Committee a fortnight since, is that while the English branch has £37,000 of assets and is mortgagee of the General Council's possessions to the extent of £25,000, and while the Scottish branch has over £6,000 in hand, the Irish branch has only £62 to its credit and will be unable to continue to pay its office expenses unless it is speedily relieved by a strategic movement. This state of affairs is, we submit, discreditable to the General Council because it was anticipated when the existing financial scheme was constructed, and was pointed out years ago as a natural consequence of the method of division. As we recently showed the Irish Branch Council must necessarily starve because it receives only in exceptional cases the registration fees of Irish students. Apart from the fact that a large proportion of such students go to Scotland for qualification, there remains the fact that those who do qualify in Ireland seldom register there or register at all, until an assistantcy in England or a public appointment there compels them to do so, in which case, perhaps years after qualifying, they register in England, and their five pounds each goes to swell the bloated revenue of the English branch. This disability applies only to a poor country like Ireland, where the parent is exhausted by the cost of his son's education and diploma fees, and is glad to postpone the payment of £5 for registration to as distant a date as possible. The obvious escape from this difficulty is to require every candidate seeking registration to register in the country in which he received his qualification. To do so would not cost him sixpence extra, and would be an equitable arrangement.

The Affiliation of Colleges to Universities.

It is highly desirable that some settled procedure should be adopted in respect of the powers granted to universities to affiliate to themselves colleges and other similar institutions, and the Earl of Kimberley was well inspired in directing attention to the subject last week in the House of Lords. His lordship pointed out that while the University of London was only authorised by its statutes to affiliate educational institutions situated within the administrative county of London, the University of Birmingham was subjected to no such restriction, or, indeed, to restriction of any sort. Victoria University was treated on equally generous terms, and this opens up the possibility of a down-grade competition between universities in this direction. Obviously the activity of each university ought to be restricted to certain geographical limits; in other words, each university should have its well-defined sphere of influence. It is somewhat remarkable that this point was not raised during the many months during which the draft charter was exposed to public criticism; but it is never too late to mend, and advantage ought to be taken of the first convenient opportunity to establish a regulation imposing reasonable limitations.

The Army Medical Department in Parliament.

THE recent debate in Parliament on the Army Medical Department really justifies the hope that in future this branch of the Service will receive better and more considerate treatment than has been its fate hitherto. It is something that the Government should feel called to recognise and bear testimony to the "fortitude, courage and efficiency" of the medical officers, men, it was added, who are not exalted by the joy and intoxication of battle, but are sustained in the discharge of their duty solely by their devotion to suffering humanity. It is beginning to dawn upon the military authorities that it may be necessary to offer greater inducements to medical men to become candidates for the Service. Certainly, as far as one can form an opinion, the supply is not likely to prove equal to the demand, and no amount of pressure on the medical schools will prove of much avail in inducing men to come forward in sufficient numbers unless the attractions of the Service are increased.

Anti-Typhoid Inoculations in the Army.

WHEN the medical history of the South African campaign comes to be written, one of the most interesting and instructive chapters will certainly be the results of the anti-typhoid inoculations which, we learn, have been carried out on a fairly large scale. Though purely voluntary, as many as 60 per cent. of the men in some regiments have availed themselves of the protection promised by this method. It is too early at present to draw any conclusions from the results obtained, for these will require the closest scrutiny before they can command acceptance. Even as matters stand, we are assured that the amount of sickness has been vastly less than that of any expedi-

tion of which a record exists in this or any other country.

The Walker Prize.

THIS prize, which is in the gift of the Royal College of Surgeons of England, was founded by Mr. Charles Clement Walker with the object of encouraging the investigation of the pathology and therapeutics of cancer. Although it is not intended that essays should be submitted in competition for the prize or that those who are anxious to obtain it should be called upon to submit their names as candidates, yet it is hoped that the knowledge of the reward which may be obtained and the distinction which it will confer on its recipient will prove an incentive to those who are occupied in the study of this disease. The prize is open to persons of all nationalities, and the Council will be glad for information from time to time of investigations that are being pursued in relation to this disease, so that they may be furnished with all that is necessary to guide them in selecting the fittest recipient for the prize. The prize is awarded every five years, and amounts to £100.

The Public Sale of Diseased Meat.

THE Belgian Government has taken under its patronage the sale of tuberculous meat on condition that it is previously sterilised, and the official price is at the rate of about twopence per pound. The money, after paying expenses, is to go to compensate the owner of the diseased animal. This is very bad, but not so bad as the sale a few years since, under the patronage of the Irish Local Government Board, of large quantities of pleuro-pneumonic beef, which was got rid of by the Dublin Board of Guardians, secretly, without sterilisation or any other precaution, at the same price, and was innocently consumed by the Dublin citizens.

Medical Experts at Fault.

THE New York *Medical Record* relates a curious story in connection with an action for damages brought in the Californian Law Courts by a woman who had been injured in a tram-car accident. She was examined by several physicians who testified that she had an abdominal tumour, probably ovarian, and it was alleged that the tumour was the result of the accident. Ten days after the trial the woman gave birth to a child at full term, and the verdict was reversed on appeal in consequence.

Lady Prosecutors.

AT an inquest held at Belfast ten days since the Coroner remarked that the post-mortem examination had been carried out by Dr. Harriett Niel, of that city, much to his satisfaction, and that this is the first instance on record of such a duty having been discharged in the kingdom by a lady.

VINEGAR is stated to be an effectual remedy for burns caused by carbolic acid, both internal and external.

Street Noises.

THAT it is desirable to control the medley of discordant sounds in our streets none will deny, except perhaps a handful of interested musicians and news-vendors. How far the principle, excellent in itself, can be extended is another matter. The Bill to be brought shortly before the House of Commons apparently concerns itself with itinerant musicians only, and leaves the rest of the disturbances severely alone. What is to be done with noisy vehicles? In all the long list of jangling discords that rack the wearied brains of the town dweller those due to carts may be given first place. The modern citizen is a man of nerves, and there could be no more certain instrument of torture invented for his despoite than, say, an average stiff-built railway van. The approach of that commercial carriage is heralded by a distant rumbling that gradually swells to an infernal avalanche of creakings, thunders, rattlings of chains, thumpings and crashings, as though an avalanche were in collision with an express train, until the evil thing is overpast and rolls away into the sea of nothingness. The only chaos of the kind comparable to a van of that type is that set up by a hand milk-cart. Cannot Parliament do something to control such noises as these, which are gradually but surely sapping the nervous vitality of the nation? The whole noise of carts is preventible. Will not the worthy Commons, ever anxious for the welfare of their country, step in and prevent it? India-rubber tyres, good springs, and attention to the commonplaces of cart construction, and the thing is done. A Government that would legislate in that direction could not fail to secure the approval of the medical profession notwithstanding the fact that its faith in the wisdom of legislators has received a rude shock of recent years by the abolition of compulsory vaccination.

An Unvaccinated Population.

TIME alone will reveal the full extent of the policy of the present Government in rendering vaccination non-compulsory. Ever since the Bill was passed it has been the effort of supporters of the measure to show that under the new scheme of domiciliary visitations the actual number of vaccinations has greatly increased. Lord Salisbury, indeed, made a categorical statement to that effect in a passage that had an enormous press quotation. With regard to the position thus assumed there is no doubt that many waverers were prevailed upon to have their children vaccinated by the friendly pressure of the medical men who visited them in their homes. Beyond this margin of dubious folk, however, stood the misguided army of stalwarts, the root-and-branch opponents of vaccination, with whom the only available argument is the strong hand of the law. This section is now upsetting the roseate theories of Lord Salisbury and Mr. Balfour as to the increase of vaccination under the new Act. To take an example: in London the district of St. Pancras show that the number of public vaccinations was 1,956 in 1898, and 1,628 in 1899, a decrease of 32. In 1898 there were 4,247 certificates of successful vac-

cination handed in to the vaccination officers as against 3,198 in 1893. When one learns that about 7,000 children were born in this populous parish in the year 1899, and that less than half of them have been vaccinated, the conclusion is inevitable that an enormous unvaccinated population will spring up in that district within the next few years. Possibly the great epidemic of small-pox that has been predicted as an inevitable result of Mr. Balfour's Act will choose St. Pancras as a favourable field of operations.

Intestinal Irrigation.

OF late years the value of irrigation of various disordered conditions of the intestinal tract has become widely recognised. It has been advised in diarrhoea, enteric fever, dysentery, cholera, and other more or less severe maladies. The method has been applied extensively in infantile diarrhoea, and has been followed by good results, especially when the lower part of the intestine has been chiefly attacked, as in forms characterised chiefly by colitis and ileo-colitis. Salt has been generally added to the fluid, of which a large quantity is slowly injected into the bowel. The action is probably twofold, first, by the mechanical removal of bacilli and other irritant substances from the mucous membranes, and, secondly by the antiseptic and stimulant action of the salt. A good practical rule is to give the clyster cold when the patient is feverish, and hot when the general state is one of coldness and collapse. Under the latter circumstances a portion of the injected liquid is doubtless absorbed and acts as an equivalent to the injection of normal saline fluid into the circulation. When used at the proper stage of the disorder there can be no question that the physician has a potent remedy against the summer diarrhoea of children in the shape of intestinal irrigation. The plan is worthy of an extended trial in cholera, when coldness and collapse, with rapid loss of body weight, are marked signs and symptoms of the disease. It is interesting to note this modern development of the old-fashioned clyster, the use of which was almost entirely restricted to the relief of constipation. Among the advantages of intestinal irrigation over drugs administered by the mouth is the simplicity and directness of the method and the absence of pain and depressing reaction.

Unqualified Prescribing in Hospitals.

FROM time to time public attention is drawn to the fact that students carry on a good deal of the out-patient practice of our medical charities. A patient treated in this way dies, and the investigation of the coroner reveals the fact that his case has been woefully misunderstood, and that he has not been seen at all by qualified medical man. Strong remarks are usually made by the coroner and jury, and a scathing paragraph runs a seven days' round in the newspapers under the heading of "Another Hospital Scandal." There the matter rests, and things go on as before. Last week Guy's Hospital figured in an unhappy pillory of the kind. From the evidence it appeared that a mother took her six-weeks-old

child to the hospital, where a student told her there was nothing the matter, but told her to come again next day. The night after her visit the baby died, and medical evidence declared that death was due to marasmus and congestion of the lung. The coroner remarked that it was an extremely improper practice that patients should be attended to by unqualified men without being made aware of the fact. His view would be shared, we should imagine, by all candid men. It is intolerable that free medical advice and medicine should be given to all comers at hospitals by anyone at all, much less by unqualified practitioners. Students at such places should work only under proper supervision, and we cordially agree with the rider appended to the verdict in the above case, namely, that in future every case at the hospital should be examined by a qualified medical man, and a record kept of treatment. It is not pleasant to think that medical students are enlisted in the ranks of that unqualified competition that presses so hardly on the main body of the profession. Every patient thus treated, if able to pay a small fee to a medical man, may be regarded as a direct loss due to unfair competition.

Consultations by Telephone.

A CORRESPONDENT calls attention to a new feature of medical practice which will call for deliberation in the near future, *viz.*, whether a medical man is justified in charging for consultations by telephone, and if so on what scale? Now that the use of this instrument is becoming general the point is one of interest, the more so because the public in general do not appear to fall in quite readily with the idea of paying for advice given in this way. Obviously the way in which the advice is conveyed has no bearing on the question of the fee. It is, we suppose, customary to charge for advice given by letter, and there is no valid reason why telephonic consultations should stand on a different footing. In point of law it can hardly be supposed that the liability could be successfully disputed, and no reasonable person, we apprehend, would maintain his objection once the matter had been placed before him in a proper light.

Bejewelled Hospital Patients.

DURING the hearing last week of a charge of robbery brought by one ex-hospital patient against another, it transpired that the complainant, who had been an in-patient at Charing Cross Hospital, had lost a gold watch and chain, a silver match-box, a gold ring, and a diamond scarf pin, valued at £40. This throws a curious sidelight on the much-vaunted measures for the prevention of hospital abuse, and one cannot but wonder where the line is drawn in the matter of deserving applicants for this form of charity. Possibly the authorities of the hospital in question might like to offer a few words of explanation as to the circumstances under which a patient who had all this valuable property in a box in his night table was received and allowed to remain.

The Action of Abortifacients.

AN American physician, Dr. L. S. Alexander, asserts that the ingestion of oxytocic drugs taken immediately after a missed menstrual period for the purpose of establishing the flow has the effect of causing the contraction of the circular fibres of the Fallopian tube, thus preventing the descent of the fertilised ovum, with consequent extra uterine pregnancy. This ingenious theory is not in accord with the generally-received view that in the healthy female impregnation invariably takes place in the uterine cavity. The denudation of the Fallopian mucous membrane of its ciliated epithelium as the result of chronic inflammation was insisted upon by Mr. Lawson Tait as an essential condition of ectopic gestation, and although this view may not be absolutely correct there is reason to believe that under ordinary circumstances the spermatozoon does not penetrate the tube but awaits the arrival of the ovum in the uterus.

Gas Fires.

THE conveniences of using gas for heating purposes are no doubt numerous, and though the cost of supply greatly exceeds that of coal, there is much saving in trouble and time to those to whom these are of importance. One point, however, requires some attention, where gas fire-places, that is, open grates, are fixed in houses. It is found that the combustion products of gas, namely, the fumes of carbonic acid and carbonic oxide, which ought to be entirely carried away by the chimney, are very liable in some amount to come back into the room, and we all know what poisonous effects are produced when we breathe them. We were much surprised to see a gas stove of considerable size exhibited in one of our leading thoroughfares with a large placard above it stating that a flue was not required. It is necessary to protect those who are ignorant of chemistry and physiology, and do not at once appreciate the dangers attending the use of a gas stove not provided with a flue. We think it well to draw the attention of our readers to a subject of real importance to the public, and one, moreover, of which members of the medical profession are the most capable of judging. Great improvements are required in ordinary gas fire-places to secure complete safety from poisonous fumes, since these are not carried away as they should be.

Midwives Legislation in New York.

A BILL for the regulation of the practice of midwifery and for licensing midwives has been brought before the New York State Assembly and is at present being criticised by the medical press. The general view seems to be that no such legislation is called for.

A DEATH from chloroform is reported from Cupar, Fife, the victim being a blind organist who was about to undergo a dental operation. Unfortunately the report does not contain sufficient details to justify any conclusion being drawn from the mishap.

WE understand that Mr. MacWalter, of Dublin, who was called upon to resign, and did resign, the diploma held by him from the Irish College of Physicians because of his having adopted what that college considered to be unworthy means of obtaining practice, was also called upon by the Council of the College of Surgeons to show cause why his diploma should not be suspended for infraction of the regulations of the College. We understand that he offered an unqualified written apology and an assurance that he would not offend in future, and that the Council of the College has, for the present, foregone any further action in the matter. Mr. MacWalter is the gentleman who, through the columns of the *Chemist and Druggist*, recently threatened the MEDICAL PRESS AND CIRCULAR with an action at law for having stated, as we do now, the naked facts.

MUCH angry feeling was recently caused in Australia by the connection of a well-known surgeon with a company, for the sale of "preventives," &c. At a meeting of the Branch British Medical Association, of which he is a member, the Council came to a resolution, by 14 against two, that he be expelled. The two objected to the extreme measure. It will be submitted to the general meeting at an early date. Should the Council be defeated, it is anticipated that they will resign in a body, and will lead to a disruption of the branch.

LORD METHUEN's despatch in the *London Gazette* of March 16th recommends Major O'Donnell and Lieut. Delass, of the Royal Army Medical Corps, for "indefatigably attending the wounded under fire"; also recommends Lieut. Douglas, of the Royal Army Medical Corps, for "great gallantry and devotion under a very severe fire in advancing in the open and attending Captain Gordon, and afterwards attending Major Robinson and other wounded men under a fearful fire." We trust that these officers will be duly rewarded with the "Victoria Cross."

THE death is announced of Dr. Leslie E. Keeley, who, says the *New York Medical Record*, "won fame of a certain kind and a large fortune" by exploiting the "gold cure" method of treating inebriety. We had occasion to make this gentleman's acquaintance some years ago in connection with legal proceedings which he thought fit to initiate against the MEDICAL PRESS AND CIRCULAR for venturing to characterise the "cure" as a fraud and its inventor as a quack. When the proceedings reached the stage for providing security for costs the matter was allowed to drop.

A BILL for the compulsory adoption of the metric system in the United States is now before Congress, and, if passed, will become operative on the birth of the year 1901.

It was stated in Parliament last week that 25 per cent. of the recruits for the Navy are rejected on account of bad teeth. In the Army during 1899 bad teeth accounted for 7.74 of the total number of rejections, equal to 2.5 of the total number of recruits.

THE Home Secretary, in reply to Sir Walter Foster, said that the subject of death certification was still under consideration, but that no bill dealing therewith could be promised for this session.

DR. S. M. HEBBLETHWAITE, of Harewood (Yorks) was last week condemned to pay £100 by way of damages in respect of a statement made by him reflecting on the personal character of a local butcher and on the quality of the meat supplied by him.

PERSONAL.

SIR WILLIAM PRIESTLEY, M.D., who is suffering from cancer of the liver, is reported to be in a very critical state.

DR. KAPOSI, of Vienna; Dr. Erb, of Heidelberg; and Dr. Hansen, of Bergen, have been elected foreign correspondents of the French Academy of Medicine.

DR. C. D. F. PHILLIPS, the well-known therapist, of London, is to have conferred upon him the honorary degree of LL.D. by the University of Edinburgh, on April 14th.

PROFESSOR PAUL EHRLICH will deliver the Croonian Lecture before the Royal Society on the 22nd instant the subject being Immunity, with special reference to cell life.

DR. LEITH NAPIER, of South Australia, who was so severely injured not long since by a fall from his horse, has so far recovered that, says the *Argus*, he is now able to smoke.

PROFESSOR D. E. HUGHES, the eminent electrician, has bequeathed a sum estimated at £400,000 in aid of Middlesex, London, King's College, and Charing Cross Hospitals.

DR. WILLIAM SELBY CHURCH, President of the Royal College of Physicians, has been elected a member of the Athenæum Club, on the ground of "distinguished eminence" in science.

LIEUTENANT-COLONEL ARTHUR THOMAS SLOGGETT, R.A.M.C., and Mr. Edmund Owen, F.R.C.S., have been appointed Knights of Grace of the Order of the St. John of Jerusalem in England.

THE degree of M.A. (*honoris causa*) has been conferred by the University of Oxford on Surgeon-Major-General (retired) Alexander Frederick Bradshaw, C.B., M.R.C.P., honorary surgeon to the Queen.

IRISH MEDICAL SCHOOLS' AND GRADUATES' ASSOCIATION.

THE 22nd Annual General Meeting of the above Association was held on Saturday, March 17th (St. Patrick's Day), at the Hotel Cecil, London.

Dr. Phillips-Conn, Vice-President, in the absence of Sir William Thomson, now in South Africa, the outgoing President, inducted Inspector-General Lloyd, R.N., as President for the coming year.

There was a very large attendance of members, including Dr. Mapother (Vice-President), Dr. Fegan (Ex-President), Dr. Gilbert-Smith (Chairman of Council), Dr. E. Irwin Scott (Vice-Chairman of Council), Dr. Jocelyn Swan (Hon. Treasurer).

Surgeon-General Sibthorpe, C.B., I.M.S., Dr. F.M. Pierce (Manchester), Fleet-Surgeon Delmege, R.N., Mr. Arthur Barker, Dr. Mouillot (Harrogate), Colonel McNulty, C.B., A.M.S., Dr. Swanton, Colonel Boileau, A.M.S., Mr. Hepenstal Ormsby (Dublin), Colonel Thornhill, I.M.S., Dr. Holmes Joy (Tamworth), Dr. W. H. Bourke, Colonel Tuohy, I.M.S., Dr. Crespi (Wimborne), Dr. Hamilton Bland, Dr. Helen Webb, Mr. Charles Ryall, Dr. G. Roe Carter, Dr. Ormsby Wiley, Dr. Gilbert Richardson, Dr. Wheeler O'Bryen, Dr. James Donclan, and the two Honorary Secretaries, Dr. James Stewart and Mr. Freyer.

The Annual Report, presented by the Council, drew attention to the fact of the Association having "attained its majority" during the past year, which was one of marked prosperity, the numbers on the roll at present being 726, notwithstanding the deaths of an unusually large number of members, including Professor Cuming (Ex-President), Dr. Waring, R.N. (Vice-Chairman of Council), Dr. Boyd (Jamaica), Dr. William Carte (Dublin), Major Dorman, R.A.M.C., Dr. Frazer (Dublin), Dr. Halton (Barnsley), Dr. Maurice Kenny (Selby), Mr. W. Ireland Wheeler (Ex-President, R.C.S.I.), and five others. Great regret was expressed at the death of the senior honorary member, the late Sir James Paget, Bart., "a warm friend of the Association, who frequently expressed his sympathy with the efforts of the Council to induce the governors of English public hospitals to remove from their statutes disabilities affecting Irish diplomats." Satisfaction was expressed at the increasing number of those attending the business and social gatherings of the Association, at one of which—the "Coming of Age" celebration last November—no less than 401 members and their friends were present.

Reference was also made to the very large number of R.A.M.C. officers holding important medical posts at the front in South Africa, being members of the Association.

The accounts of the honorary treasurer showed a credit balance of £130 2s. 3d. The report having been adopted, a warm vote of thanks to Sir William Thomson and the other retiring officers was passed with acclamation. The following appointments were made for 1900—1901 as a result of a ballot, which took place at the close of the meeting:—President-Elect, Dr. William Frazer (Bournemouth); Vice-Presidents, Dr. Phillips-Conn (Reading), Professor Alexander Macalister, F.R.S. (Cambridge), Dr. Mapother, and Sir William Thomson, F.R.C.S.I.; Honorary Treasurer, Dr. Jocelyn Swan; Honorary Auditors, Colonel Tuohy, I.M.S., and Dr. F. H. Daly.

Members of Council (elected):—Colonel Boileau, A.M.S., Dr. W. H. Bourke, Campbell Boyd, Bulger, T. H. Crampton, J. Donclan, Surgeon-General Evatt, A.M.S., St. L. Finny, More-Madden, Mouillot, J. W. O'Bryen, Surgeon-General Rice, C.S.I., I.M.S., G. Richardson, C. Ryall, J. G. Shea, J. H. Swanton, Colonel Thornhill, I.M.S., and W. H. White.

This closed the proceedings.

The festival dinner in honour of St. Patrick took place on Saturday evening last, at the Hotel Cecil. Inspector-General Lloyd, R.N., the President, occupied the chair, and he was supported by some 230 members and their guests, including Mr. Lecky, M.P., Sir Dennis, Fitzpatrick, Surgeon-General Jameson (Director-General A.M.S.), Dr. Mapother and Dr. Phillips-Conn (Vice-Presidents), Fleet-Surgeon Delmege, R.N., Dr. W. T. Freeman, Colonel McNulty, A.M.S., Surgeon-General W. Don, A.M.S., Surgeon-General W. Hamilton, A.M.S., Dr. Gilbert-Smith (Chairman of the Council), Dr. W. Playfair, Dr. J. Swan (Hon. Treasurer), and Mr. Freyer and Dr. James Stewart (Hon. Secretaries). During dinner the Chairman sent the following telegram to Her Majesty:—"On behalf of the Irish Medical Schools' and Graduates' Association here assembled, I beg to offer your Majesty our heartfelt gratitude for your Majesty's grateful recognition of the services rendered in South Africa by your Majesty's Irish soldiers, our fellow-countrymen, and for the highly-prized permission to wear the shamrock on St. Patrick's Day. I humbly convey to your Majesty our full appreciation of your Majesty's gracious thought of

our country at this time, and earnestly pray that your Majesty's approaching visit to the Irish metropolis may be all that our loyal Irish hearts can wish for our beloved Queen." Later in the evening a reply was received from the Queen, who expressed her gratification at the good wishes in regard to her forthcoming visit, "to which event Her Majesty looks forward with much pleasure." A telegram was also dispatched to Lord Roberts, as follows:—"Accept our best St. Patrick's Day wishes. Kindly convey them to our fellow-countrymen under your command. We drink to your health and your safe return." The health of Lord Roberts was enthusiastically honoured. Surgeon-General Jameson, in responding to the toast of "Our Defenders," referred to the use of hot pitch to wounds in years gone by as the first instance of antiseptic surgery. Coming to more recent times he pointed to the Crimean campaign as the first occasion on which the duty of the State to the individual was recognised. Taking the statistics of the last eighteen expeditions, he pointed out that the French had lost 26½ times more soldiers from disease than we had done. At Madagascar they lost 32½ per 1,000 from disease alone, whereas in Ashantee we only lost 7. In responding to the toast of "Our Guests," which was proposed by Mr. Freyer in some eloquent phrases, Mr. Lecky said that not only were they proud of the Irish soldiers and generals in South Africa, but also of the Irish doctors, a large number of whom had gone out to organise hospitals and to do all in their power to relieve the sufferings caused by the war. What had happened in South Africa, and what was going to happen in Ireland when the Queen went there in the course of a few days, would have a most improving and salutary effect upon Irish public opinion. Sir D. Fitzpatrick also responded. Musical selections were rendered in the course of the evening by Miss Elsie Nicholl, whose admirable voice was greatly appreciated, by Mr. William Nicholl, and Dr. T. T. de Z. Marshall, and altogether a very pleasant evening was spent.

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

CONSULTATIONS BY TELEPHONE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I have the good fortune, if good fortune it be, to have a telephone which usually serves the purpose of arranging consultations, &c. On several occasions of late, however, patients of mine have rung up to ask my advice, in some instances at night, in urgent cases, advice which it has been in my power to give.

The point which I wish to raise is my right to charge for such consultations, one of the patients having point blank refused to pay my fee on the ground that it was merely preliminary to a visit on the following day. It seems to me that if patients find it convenient to call one up in order to ascertain what to do in cases of emergency we are fully justified in charging, just as for an ordinary consultation, but there does not seem to be any precedent, and I should be glad to have the opinion of your readers on the point.

I am, Sir, yours truly,

G. P.

Obituary.

WILLIAM CHAPMAN GRIGG, M.D., M.R.C.P.

We regret to have to chronicle the death of Dr. William Chapman Grigg, late of Curzon Street, Mayfair, which took place on the 12th inst. at Wynberg Hospital, South Africa, from typhoid fever contracted at the Mudders River. But a few short weeks since, Dr. Grigg, who had recently resigned his appointments as assistant obstetric physician to the Westminster Hospital and physician to Queen Charlotte's Hospital, and had retired from active practice, left this country on the way to the

front, where, in spite of his age—for he was in his sixty-first year—he hoped to be able to render useful service. Scarcely, however, had he arrived at the front ere he contracted the disease to the effects whereof he promptly succumbed.

Dr. Grigg graduated at Edinburgh in 1870, and became a member of the Royal College of Physicians in 1872. He was a well-known figure in London medical circles, and was a past president of the British Gynaecological Society. Genial in his manners and hospitable in private life, he had endeared himself to a large circle of friends who will mourn his loss.

Literature.

CARNOT'S REGENERATIONS D'ORGANES. (a)

THIS little work comprises three chapters. The first deals with regeneration in general, and is subdivided into two parts: (1) Physiological, traumatic, and pathological regenerations; (2) The mechanism of regeneration. This treats of mesodermic regenerations, and is subdivided into (1) regeneration of the blood, (2) of hæmatopoietic organs, (3) of the vessels, (4) of connective tissue, (5) of the bones, (6) of cartilage, and (7) muscular regeneration. The third chapter is devoted to epithelial regeneration, and comprises regeneration of the nervous system, of the epidermic surfaces, of mucous passages and cavities, and finally of glandular organs. The author begins by saying that regeneration must be regarded as the replacing in a living organism of a part that has disappeared through a neo-formation resembling it morphologically and physiologically; he takes his readers through the lowest scale in the zoological and embryological series—protozoa, echinodermata, &c., to the vertebrata; he sums up the mechanism by saying:—"Physiological regeneration is an unceasing phenomenon which constitutes life itself, and accidental regeneration seems to follow the same laws, whilst being at the same time very much more intense." The remainder of the work, as seen by the titles of the chapters and their subdivisions, is devoted to the medico-surgical application of regeneration of various organs and tissues, and is very instructive and interesting, the references to the researches of other savants being concise and to the point.

Medical News.

Dublin Hospital Sunday Fund.

THE annual meeting of the friends and supporters of the Dublin Hospital Sunday Fund will be held at the Leinster Lecture Hall, Molesworth Street, Dublin, on Friday next, March 23rd, 1900, at half-past four o'clock. At this meeting the report of the Executive Council and statement of accounts for the year 1899 will be read, and the usual business transacted.

First International Congress of Professional Medicine and Medical Deontology.

THE committee of the International Congress of Professional Medicine and Medical Deontology, which will be held in Paris from July 23rd to 28th, begs to acquaint the medical profession that:—A reduction of 50 per cent. on the rates of the Transatlantic Company's steamers will be allowed to all members of the Congress who have sent in their subscriptions before June 20th, 1900. The documents necessary to obtain this reduction will be drawn up at the same time as the cards of admission to the Congress. The railway ticket will be available for one month, from July 20th to August 20th. With regard to lodging in Paris, the committee has obtained special terms from various agencies. Detailed memoranda dealing with the proposals made by these agencies are now in the hands of the presidents and secretaries of the

organising committees and of the foreign national committees, to whom members of Congresses, desirous of obtaining further information, are requested to apply.

Those who intend to join the Congress should send their subscriptions—fifteen francs for members, ten francs for associates, accompanied by their card—to the treasurer of the Congress, M. Pierre Masson, 120, Boulevard St. Germain, Paris. Associates (medical students, wives of members) are eligible for the reduced railway rates. They will, however, have no right to the publications of the Congress.

Hunterian Society.

AT the annual general meeting of the Society on February 14th, 1900, the following Fellows were duly elected as office-bearers for the ensuing year:—President: J. Dundas Grant, M.D. Vice-Presidents: G. Newton Pitt, M.D., Hope Grant, M.D., Arthur T. Davies, M.D., and Sir Hugh Beevor, Bart, M.D. Treasurer: R. Hingston Fox, M.D. Trustees: H. I. Fotherby, M.D., and F. M. Corner. Hon. Librarian: T. H. Arnold Chaplin, M.D. Orator: John Poland. Secretaries: J. H. Targett, M.S., and T. Glover Lyon, M.D.

Assistants' Bond Suit.

A LEGAL point of considerable interest to medical men was tried in the Chancery Division on Thursday last before Mr. Justice Cozens-Hardy. Dr. W. V. Sinclair, of Honiton, sought to restrain Dr. Tonge from practising within a specified radius of Honiton, and to obtain specific performance of an agreement to execute a bond in favour of the plaintiff.—For Dr. Sinclair it was stated that in April, 1897, Dr. Sinclair accepted Dr. Tonge as an out-door assistant, and the latter on October 20th wrote that he would sign the "usual bond." An agreement was drawn up by a solicitor but was not signed, though the defendant wrote on a draft promising that he would not practise in opposition to Dr. Sinclair, either as physician or surgeon, or assistant to any other medical man in Honiton or within five miles thereof, for ten years, if Dr. Sinclair adhered to his arrangement that defendant should act as his assistant for two years. Defendant left plaintiff's employment in April, 1898, without having signed the bond. On September 13th, 1899, defendant wrote to Dr. Sinclair that he had accepted an appointment at Beer, and he was now carrying on his profession at that place.—His Lordship said plaintiff could not get specific performance of an agreement so vague. There could be no custom in the medical profession for the execution of bonds containing covenants for a fixed number of years or a fixed area.—Mr. Terrell sought to put in as evidence a verbal agreement as to the term. There was mention of bond, but not of time or distance.—His Lordship held such evidence to be inadmissible, and dismissed the action with costs.

"Perceval Memorial," Queen's Co.

A MEETING in connection with above was held on Saturday week. The meeting had under consideration the memorial which has been erected to the memory of the late Dr. William Perceval, who for many years, was dispensary Medical Officer for Stradbally. The memorial takes the form of a market house or "place," as it is described in the memorial tablet. It was erected at a cost of about £164, and was subscribed to by members of all classes and creeds of the community. The practical form the memorial has taken will form a fitting and appropriate tribute to the memory of one whose whole life was devoted to the promotion of the material and social well-being of those among whom he lived and laboured, and for whom he was ever ready to make any and every sacrifice. The memorial tablet contains the following inscription:—"In memory of William Perceval Esq., M.D. who died January 4th, 1899. This market place has been erected by his friends as a token of the affection and esteem in which he was held by all classes during the 54 years that he practised in Stradbally, and to perpetuate the memory of his unselfish devotion to duty, his large charity, and his bright and kindly disposition. August, 1899."

(a) "Les Régénérations d'Organes." By Dr. Paul Carnot. Paris: J. Bailhere et fils. P. 94.

Notices to Correspondents, Short Letters, &c.

LOCAL REPORTS AND NEWS.—Correspondents desirous of drawing attention to these are requested kindly to mark the newspapers when sending them to the Editor.

READING CASES.—Cloth board cases, gilt lettered, containing twenty-six strings for holding the numbers of THE MEDICAL PRESS AND CIRCULAR, may now be had at either office of this journal, price 2s. 6d. These cases will be found very useful to keep each weekly number intact, clean, and flat after it has passed through the post.

ORIGINAL ARTICLES OR LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

THE CROOKE DIVORCE SUIT.

JUST as we are going to press a letter reaches us from Messrs. Lewis and Lewis in reference to the paragraph which appeared in our last issue headed, "Exoneration in the Divorce Court," pointing out that far from disclaiming the paternity of the child the petitioner distinctly stated that he believed himself to be the father. We have pleasure in inserting this rectification as requested.

G.P. asks whether he is entitled to charge for making an analysis of the patient's urine, or whether this must be held to be included in the fee for the consultation.

"* There is no settled practice on this point—it must obviously depend upon the amount of his fee, and it is better to make this large enough to cover the analysis.

EAST ANGLIA.—Tobacco smoke contains a variable proportion of carbon monoxide (1 to 7%), but the deleterious effects of inhaling the fumes of cigarettes are probably due less to this source of blood intoxication than to the directly irritating effects of the pyrolytic constituent of the smoke.

M.R.—A simple and apparently effectual way of attempting the resuscitation of infants born in an asphyxiated condition is that known as Laidie's. The child is placed in hot water and rhythmic tractions of the tongue made, at the rate of about 25 to the minute. It is often necessary to persevere with the treatment for some time, and this should be done even in the absence of any indication of returning animation.

Dr. M.—We have dealt with the matter of the qualification of public analysts in the present issue.

Meetings of the Societies and Lectures.

THURSDAY, MARCH 22ND.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.—5 p.m. Dr. P. Horton-Smith: The Typhoid Bacillus and Typhoid Fever. (Goulstonian Lecture.)

FRIDAY, MARCH 23RD.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 p.m. Prof. C. Stewart: On the Protection and Nourishment of the Young in Plants and Animals.

CLINICAL SOCIETY OF LONDON (20, Hanover Square, W.).—8.30 p.m. Papers.—Dr. Hale White and Mr. Frigg: A Case in which the Attempt was made to Remove a Dermoid Tumour which growing in the Spinal Canal pressed upon the Spinal Cord.—Mr. R. Jones and Mr. Tubby: Further Experience of Cases of Spinal Rectification.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.).—4 p.m. Dr. St. Clair Thomson: Consultation. (Eye, Ear, Nose and Throat.)

FRIDAY, APRIL 6TH.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY.—1. Mr. Percy Dunn: Purulent Ophthalmia and its Treatment. 2. Dr. H. Snow: Three Cases illustrating the Clinical Behaviour of Gall Stones.

Appointments.

ALLPORT, E. H., L.R.C.P.Lond., M.R.C.S., Assistant Medical Officer for the Renfrew Road Workhouse of the Parish of St. Mary, Lambeth, London, vice J. C. Harcourt, resigned.

BROWN, W. LANGDON, M.A., M.B., B.C.Cantab., M.R.C.P., Assistant Physician and Pathologist to the Metropolitan Hospital, Kingsland Road, N.E.

BURRELL, L. C., M.B., B.C.Camb., L.R.C.P.Lond., M.R.C.S., Medical Officer for the New Sanitary District by the Richmond (Surrey) Board of Guardians.

CRAVEN, E., M.B., C.M. Edin., Medical Officer for the Chipping District of the Clitheroe Union.

EVANS, J. JAMESON, M.B., C.M., F.R.C.S. Eng., Demonstrator of Anatomy in Mason University College, Birmingham.

FRICE, STAMFORD G., M.D., B.C.Cantab., Medical Officer to the Willesden Parish Infirmary.

GILES, A. E., M.D., M.R.C.P.Lond., F.R.C.S. Edin., Honorary Gynaecologist to Out-patients, Tottenham Hospital.

HAYS, A. G., L.R.C.P., L.R.C.S. Edin., F.F.P.S. Glasg., Medical Officer for the Third Sanitary District of the Brackley Union.

HENSTED, HENRY, Jun., M.R.C.S., L.R.C.P.Lond., House Surgeon to the Royal Hants County Hospital, Winchester.

INVERARITY, JAMES M., L.R.C.P., L.R.C.S. Edin., Civil Surgeon to the 4th Battalion Scottish Rifles, now en route for South Africa.

LESLIE, E. MURRAY, M.B. Edin., M.R.C.P.Lond., Senior Medical Registrar and Medical Tutor, King's College Hospital, London.

LESLIE, E. MURRAY, M.A., M.D., M.R.C.P.Lond., Honorary Physician to In-patients, Tottenham Hospital.

MACDONALD, J. H., M.B., B.Ch. Glasg., Assistant Medical Officer (Pathologist) at the Glasgow District Asylum, Woodlee, Lenzie.

RICHARDS, H. M., M.D.Lond., B.S., L.R.C.P., M.R.C.S., Medical Officer of Health for the Borough of Croydon.

ROBE, GEORGE A., M.B., Ch.B., Senior Assistant Medical Officer at Cumberland and Westmorland Asylum, vice J. W. Leitch, resigned.

ROWLANDS, W. H., L.R.C.P.Lond., M.R.C.S., Medical Officer for the Workhouse of the Bromsgrove Union, vice C. Kidd, resigned.

SMITH, EDMUND MOODY, M.D., C.M. Edin., D.P.H. Cantab., Medical Officer of Health for the City of York.

STEBLE, HERBERT, L.R.C.P.Lond., M.R.C.S., of St Marychurch, Torquay, granted a commission as Surgeon-Captain in the Eighth Division, and is proceeding to South Africa.

THOMPSON, GEORGE W., M.B., C.M. Edin., Assistant Surgeon to the Western Ophthalmic Hospital, London.

WRIGHT, WILLIAM, M.B., B.Ch., M.R.C.S., L.R.C.P., Lecturer on Osteology and Senior Demonstrator of Anatomy in Mason University College, Birmingham.

Vacancies.

Birmingham and Midland Ear and Throat Hospital, Edmund Street, Birmingham.—House Surgeon. Tenable to October 31st next. Salary at the rate of £80 per annum, with board, lodging, and washing.

Bradford Royal Infirmary.—House Surgeon for twelve months, unmarried. Salary £110 per annum, with board and residence.

Cardiff Infirmary.—Assistant House Physician for six months. Salary at the rate of £50 per annum, with board, washing, and apartments. Also Resident Medical Officer for three years. Salary £100 per annum, with board, washing, and furnished apartments.

Cumberland and Westmorland Asylum, Garlands, Carlisle.—Junior Assistant Medical Officer, unmarried. Salary £100 a year, with board and residence.

Devon County Asylum, Exminster, Devon.—Third Assistant Medical Officer. Salary £120, rising to £150, with board, lodging, &c.

Down (County) District Asylum, Downpatrick.—Assistant Medical Officer, unmarried. Salary £100 per annum, with furnished apartments, board, washing, and attendance.

Loughborough and District General Hospital and Dispensary, Loughborough.—Resident House Surgeon. Salary £100 per annum, with furnished rooms, attendance, and board.

Royal Albert Hospital, Devonport.—Assistant House Surgeon for six months. Salary at the rate of £40 per annum, with board, lodging, and washing.

Royal National Hospital for Consumption, Ventnor.—Clinical Assistant. Board, residence and laundry provided. Apply to Dr. Parry, Resident Medical Officer.

Staffordshire General Infirmary, Stafford.—House Surgeon for two years. Salary £100 per annum, with board, lodging, and washing.

Wolverhampton and Staffordshire General Hospital, Wolverhampton.—Assistant House Physician for six months. Honorarium at the rate of £50 per annum, and board, lodging, and washing provided.

Births.

BARTON.—On March 9th, at Sunnyside, Wimbledon, the wife of Percy Frederick Barton, M.A., M.F., B.C., of a son.

GOODALL.—On March 5th, at Homerton, the wife of E. W. Goodall, M.D.Lond., of a daughter.

HARCOCK.—March 14th, at Grove House, Belsize Grove, Hampstead, the wife of William Albert Hancock, F.R.C.S., of a daughter.

HIGGINS.—On March 3rd, at Marazion, Chester Road, Erdington, Birmingham, the wife of W. A. Higgins, M.D., of twins (girls.)

Marriages.

M'CLURE-GANE.—March 16th, at St. Matthew's, Upper Clapton, Charles Thomas M'Clure, M.R.C.S., L.R.C.P., eldest son of Thomas M'Clure, M.D., F.R.C.S.I., of New Whittington, Derbyshire, to Gertrude, daughter of the late William Lane Gane, of St. James's Lodge, Clapton.

TOWNSEND HODGSON-BURNETT.—On March 11th, at Genoa, Stephen Townsend, F.R.C.S., of the Inner Temple, London, to Frances Hodgson-Burnett, of Maythorn Hall, Bolvenden, Kent.

Deaths.

GRIGG.—March 12th, at Wynberg Hospital, South Africa, of enteric fever, William Chapman Grigg, M.D., of Curzon Street, aged 60.

JACKSON.—February 16th, Hadley C. Jackson, M.R.C.S., Medical Officer, Uganda Protectorate, British E. Africa, aged 28.

WILLIAMS.—March 12th, at Brynmor, Penryn, Carnarvonshire, John Cadwaladr Williams, M.B., C.M. Edin., M.R.C.S. Eng., L.R.C.P.Lond., of Grange Road West, Middlesboro'-on-Tees, aged 31.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXX.

WEDNESDAY, MARCH 28, 1900.

No. 13.

Three Lectures ON THE SURGERY OF THE STOMACH. (a)

By A. MAYO ROBSON, F.R.C.S. ENG.,

Member of the Council and Hunterian Professor of the Royal College of Surgeons of England; Emeritus Professor of Surgery in the Yorkshire College; and Senior Surgeon to the Leeds General Infirmary.

AFTER some preliminary remarks on the anatomy of the region the lecturer proceeded to discuss the diagnosis.

This necessitates both a general and a special inquiry, the former involving the questions of age, sex, occupation, habits, mental, moral, and physical condition, and the history both of the patient and of the disease; and the latter, which is the only part which we need now consider, including all the information that the surgeon can elicit by a physical examination.

Inspection.—Dilatation of the stomach can often be ascertained by inspection, and it may in extreme cases be seen to occupy all the five regions of the abdomen, as shown in the diagram. If the dilatation is atonic the swelling persists without visible peristalsis; but if it is due to contraction of the pylorus visible peristalsis from left to right can frequently be plainly seen. Tumours of the pylorus and of the body of the stomach are frequently visible through the abdominal wall, and in an early stage they can be seen to move downwards on inspiration. Inspection will reveal the shallow, rapid costal breathing induced by pain at the commencement of peritonitis and by distension in the later stages, just as it will demonstrate the sighing respiration in internal hæmorrhage and the irregular catching breathing in diaphragmatic peritonitis or subphrenic abscess and the swelling in the upper abdominal region when the pus tends to make its way forward.

Palpation.—If the upper abdomen is rigid it will raise the suspicion of local peritonitis, especially if there is tenderness on pressure. Should there be a tumour, its nodular character, if malignant, will easily be felt, and if it be an early stage of cancer of the pylorus it will, in all probability, be freely movable. If there be malignant disease of the body of the organ it will move downwards on respiration, but not freely from side to side. It will be found better, as a rule, to slide the hand over the abdomen, and not to raise it from the surface, thus avoiding fresh defensive contraction of the muscles, which will occur if the hand be raised and replaced on the abdomen. It may sometimes be advisable to employ gentle massage in order to elicit the presence of a tumour of the body of the stomach, or of the pylorus, due to muscular spasm, as in pyloric stenosis. In some cases of ulcer a distinct tumour may be present at one time, owing to the contraction of the muscular coat, and

absent at another, the tumour only being felt distinctly when the spasm is present. In diagnosing between atonic dilatation of the stomach and that due to obstructed pylorus, the vermicular contractions felt under the palpating hand are of the first importance. Where, as occasionally happens, palpation is impossible on account of rigidity of the muscles or obesity, an examination under an anæsthetic may be advisable. Bimanual examination with one hand in the loin and the other on the surface of the abdomen will frequently give increased information as to the size of the tumour. A tender and rigid epigastrium suggests ulcer of the stomach, and the situation of the tenderness is frequently a good guide to the site of the ulcer; for instance, if the tenderness be under the left costal margin and the left rectus be rigid, especially if the patient be relieved by assuming the dorsal decubitus, in all probability the ulcer will be on the anterior surface; whereas if the tenderness is on the right of the middle line between the umbilicus and the right costal margin the probability is that the pylorus is the affected part. When there are symptoms of ulceration without marked epigastric tenderness and with increase of pain on dorsal decubitus, and relief is found by lying on the face, the probability is that the ulcer is on the posterior wall of the stomach. Palpation will usually bring out the character of the tumour as to smoothness, irregularity, softness, or hardness. A nodular character of the tumour, especially if associated with fluid in the peritoneum, usually indicates malignant disease. Pulsation in an epigastric tumour is often felt, and if it is due to cancer it will be non-expansile and dull on percussion. Fixation of a tumour is suggestive of perigastritis, especially if associated with tenderness, but it may also be dependent on infiltration due to malignant disease.

Percussion.—Deviation from the normal size of the stomach can usually be ascertained by percussion, first with the patient recumbent, and afterwards by mapping out the region of dulness when the patient is erect after he has drunk freely of water. After distending the stomach with air, either through a tube introduced by the mouth or by giving a dose of carbonate of soda in solution followed by one of tartaric acid, percussion readily demonstrates the outlines of the stomach and shows the position of any tumours both with regard to the orifices and to the greater or lesser curvatures; and it also enables the diagnosis to be made between a pancreatic and a stomach tumour. Percussion is also of use in demonstrating the presence of free fluid in the peritoneal cavity due to the rupture of a gastric ulcer, and for showing the absence of liver dulness under similar circumstances when free gas is present in the peritoneal cavity.

Auscultation.—Auscultation is sometimes useful in demonstrating the splashing sound in gastric dilatation and the gurgling or metallic sounds in subphrenic abscess containing gas. With one finger on the pomum Adami, with the ear in the situation

(a) Delivered at the Royal College of Surgeons of England on March 5th, 7th, and 9th, 1900.

mentioned, and with a watch in the hand, it will usually be found, when there is stricture of the œsophagus, that fourteen or sixteen seconds elapse before fluid reaches the stomach. This is a valuable addition to the ordinary well-known means of diagnosis. Spasm of the pharynx or of the œsophagus at times closely resembles organic stricture; hence, before proposing gastrostomy, an examination should be made with the patient anæsthetised.

Pain.—Though pain may be absent in some few examples it is present at some stage of the disease in the greater number of stomach ailments calling for surgical treatment, and its character and course frequently afford the most valuable means at the disposal of the surgeon for interpreting and diagnosing ailments which present few physical signs. The history of the onset of pain may show the local origin of a more general trouble. As a rule, the pain from perforated gastric ulcer, though ultimately diffused, will have been first felt in the epigastrium, and the history will point to pain after food and probably to indigestion of long standing; there will also frequently be a history of reflected pain in the left scapular region, but in some cases of pyloric disease with adhesions to the gall-bladder and liver I have found the reflected pain passing to the right scapular region. Obscure recurrent abdominal pains may be dependent on a stricture or kink of the pylorus produced by adhesions, which though not sufficient to cause obstruction may produce considerable distress and disability.

Instrumental Aids to Diagnosis.—In subphrenic abscess the exploring syringe affords useful aid in diagnosing the presence of pus and enabling the surgeon to decide on the exact site of the incision for its evacuation. Œsophageal bougies are employed in cases of dysphagia, not only for treatment, but to ascertain the site of obstruction and its nature when the question of gastrostomy arises. I prefer instruments made after the pattern of *bougies à boule* employed in urethral cases; they are not generally known, but to my mind they present great advantages both in the ease and the safety with which they can be utilised and the facility with which they can be employed to dilate a stricture. In case of starvation from stricture of the œsophagus the question of gastrostomy has to be considered, but it must first be shown that the disease is incapable of being overcome by other means. Simple stricture is rare and may frequently be efficiently treated by dilatation. Cancerous strictures, on the other hand, cannot be safely dilated and will require other treatment. If there be a history of steady loss of flesh and gradually increasing dysphagia in a middle aged or elderly patient malignant stricture will be suspected, and if on passing a bougie it be arrested just before entering the stomach the diagnosis is rendered very probable; but if there be slight bleeding caused by the bougie when gently used little doubt will be left. Spasm is most frequent in the pharynx, though it may occur in any part of the œsophagus. It usually occurs in subjects younger than in those who are afflicted by malignant stricture, and nearly always in women. It is, however, frequently associated with other nervous symptoms, it varies in intensity, and it usually yields to the passage of bougies without difficulty. If, however, a bougie cannot be passed in a case where spasm is suspected, an anæsthetic will at once settle the doubt, as under its influence a full-sized bougie usually reaches the stomach when the stricture is due to spasm alone. Electric illumination may sometimes be useful. With regard to the X-rays, I have found both the screen and skiagram of use in demonstrating the position of impacted coins and other foreign bodies. The gastro-endoscope has, however, not yet proved to be of any service.

Vomited Matters and the contents of the Stomach.—

With regard to vomit, the first thing to consider is the quantity vomited at one time. In dilated stomach vomiting usually occurs only once daily, sometimes only on every second or third day, and the quantity at one time is correspondingly large. In ulcer of the stomach a considerable portion of the last meal may be brought up within an hour or two of its ingestion and the pain it has caused is thereby relieved. The smell should be considered. The most important abnormal constituent of vomit is blood. When the existence of blood in vomit is doubtful the most reliable guide is the hæmin test. Pus is sometimes, but rarely, vomited. In considering both pus and blood in a fluid said to be vomited it must be remembered that when large quantities of fluid are expelled from the lungs—*e.g.*, on the rupture of an empyema into the lung or in severe hæmoptysis—the sensation to the patient is often as if vomiting had occurred.

Examination by the microscope is of secondary importance. In dilatation of the stomach the sarcina ventriculi is frequently to be seen, together with yeast-cells. In cancer red blood corpuscles can often be found. In reference to the diagnosis of malignant disease of the stomach the relative abundance or absence of free hydrochloric acid has been pointed out as of importance by Ewald. If free HCl be present red crystals will form; should there be much peptone present no crystals but a red paste will result. The absence or deficiency of free hydrochloric acid occurs in several morbid states, but its presence is a strong point against a diagnosis of malignant disease of the stomach. Hyperacidity is as characteristic of ulcer as diminished acidity is of cancer.

Exploratory Incision.—In only a very small percentage of cases is simple exploratory incision as a means of diagnosis necessary or even justifiable, and there can be no doubt that in some cases it has served as a cloak for carelessness or incompetence. At times the surgeon may be called on to explore the abdomen for a tumour of the stomach which it is just possible may be removed, but where it is impossible to say beforehand whether the glands are involved or the disease has invaded the adjoining parts to such an extent that the removal of the growth would be useless. Under such circumstances, when the tumour is exposed, the great gift (usually a matter of common-sense combined with experience) of "knowing when to stop" comes in, for although having made an exploratory incision may, and probably will with due precautions, have involved no risk to the patient, any interference with the tumour may inflict such injury on the growth that the surgeon is compelled to convert his harmless exploratory procedure into one of the most serious operations which, if not causing death on the table or shortly after, can lead to no ultimate good. This is sheer meddlesomeness, and for the credit of surgery, if from no higher motive, should be avoided. Very frequently, however, it is impossible to decide what surgical operation is required until the stomach is exposed and handled. I find that I have performed an exploratory operation on the stomach on eight occasions. All were malignant cases and the presence of glands or secondary nodules rendered further operation inadvisable. All the patients in these cases recovered. In some case of abdominal injury, either gunshot, stab-wound, or even injury without external wound, the severe shock, the vomiting of blood, and the general condition of the patient may lead to a suspicion that the stomach has been injured and an exploratory operation may be justified, since in case of rupture of the stomach such an injury, if not repaired, would inevitably prove fatal.

At times all the symptoms of perforating ulcer ma

be present without a previous history of ulceration and all that can be said is that a peritoneal catastrophe has occurred which threatens life. Under such circumstances an exploratory operation may be required.

Incision for Exposure of Stomach.—Although incision in the middle line between the xiphoid and umbilicus gives the readiest access to the stomach in the greater number of cases, especially if there is doubt as to what may be required, it is not always the best site. The best incision is through the inner margin of the rectus, just to the right or left of the middle line. An incision on either side gives ample room; but if the pylorus is to be attacked, it is preferable on the right; if gastro-enterostomy has to be done, it is better on the left. Afterwards, the abdominal wall is sutured layer by layer, and there is no fear of hernia or a weak scar being left; moreover, there need be no fear of extending the incision if more room be required.

Gastrotomy.—"Gastrotomy" is one of the oldest operations on the stomach, but as a diagnostic method, with a view to further treatment, gastrotomy is a modern procedure. Exploratory gastrotomy has only been performed within the last few years, and by its means an extensive and minute examination of the interior of the stomach may be made with thoroughness and safety, so that in any case calling for operation, where by other means a positive diagnosis cannot be arrived at, the surgeon is justified in opening and exploring the stomach. It may be performed (1) for the removal of foreign bodies from the stomach; (2) for the removal of foreign bodies from the lower end of the œsophagus; (3) for dilating a stricture of the œsophagus; (4) for dilating a stricture of the pylorus; (5) for the removal of a polypus or other tumour projecting into the stomach; (6) for exploration in case of intractable or bleeding ulcer; or (7) for curetting a cancer of the pylorus as in Bernays' operation.

The preliminary incision of the parietes has been described and for gastrotomy it requires to be rather free. Flat sponges or gauze pads should then be packed around the stomach so as to avoid soiling the peritoneal cavity. The edges of the wound having been retracted the stomach can now be palpated, and if anterior palpation affords no guide a tear may be made in the gastro-colic omentum which will admit the fingers to palpate the posterior surface. The stomach may now be drawn forward, surrounded by a sheet of sterilised gauze, and opened by a free incision in its longitudinal axis. Divided vessels must be seized and ligatured and the liquid contents of the stomach must be mopped or syphoned out or pushed into the duodenum. On retracting the edges of the gastric incision, the interior of the stomach will be brought into view and may be further explored by the electric cystoscope if thought necessary, as, for instance, in hæmatemesis from a small bleeding ulcer. If the posterior wall be the affected part it may be invaginated by the fingers inserted through the omental slit, pushing it forward into the wound. A tumour may now be removed, an ulcer excised, a bleeding point ligatured or cauterised, the pylorus explored and divulsed the œsophageal opening exposed and dilated, or other treatment may be carried out. For foreign bodies in the stomach there is, of course, no need to make the omental wound, and an anterior incision may at once be made and the object seized and removed. The incision in the stomach can be rapidly closed by a continuous catgut suture for the mucous margins and a continuous silk suture for the serous edges, a few Lembert's silk sutures sometimes being applied overall for greater security; the exposed parts may then be gently sponged over, the pads or sponges removed, and the abdominal wound closed without drainage. Beyond teaspoonfuls of water for

the first twenty-four to forty-eight hours all feeding is best done by enemata, and after forty-eight hours the amount of liquid food may be increased. Later, pulaceous food may be given, but it is better not to give solid food for a week, after which the treatment is as in any other abdominal case. Dr. Keen insists on the necessity in this as in all similar operations on the stomach, of washing out the organ before it is opened, of bringing it out of the abdominal cavity, and of protecting the peritoneum by a wall of iodoform gauze. Lavage is, however, undesirable in gastrotomy for hæmorrhage.

Gastrotomy may be performed for the removal of foreign bodies impacted in the lower end of the œsophagus when all attempts to recover them by the mouth have failed.

In stenosis of the pylorus divulsion has given way to pyloroplasty for the double reason of pylorodiosis having a greater death-rate and of its being liable to be followed by relapse, though it may yet be advisable in those cases of stenosis due to spasm and hypertrophy of the pyloric sphincter and in those milder forms where the sphincter may be dilated without gastrotomy by invaginating the stomach wall and gradually pushing the finger through the pyloric opening.

In simple cicatricial stricture of the œsophagus near the cardiac orifice, if dilatation by bougies is impossible or has failed to keep open the stricture, the operation of gastrotomy may be performed, and an attempt made to dilate the orifice from below. The operation has proved very successful. The operation may be performed in one or two stages; in the latter case a large gastrotomy opening must be made and the dilatation proceeded with later. The one-stage operation is to be preferred, as the finger can then palpate the cardiac orifice and a mechanical dilator may be used if necessary. For subsequent operation the gastric fistula may be left if it be thought that there may be a difficulty in keeping the passage patent by bougies introduced through the mouth.

Gastrotomy for the removal of a polypus or other growth projecting into the cavity of the stomach or occluding the pylorus is an operation seldom required, since simple tumours of the stomach are uncommon.

Gastrotomy for exploration in the case of intractable gastric ulcer not yielding to ordinary treatment will be considered more conveniently when we discuss ulcer of the stomach.

Gastrotomy for partially removing cancerous growths in the stomach by the curette is an operation that has been performed by Dr. Bernays, of St. Louis, but in view of the better results from gastrectomy or gastroenterostomy, it is scarcely likely that this operation will continue to hold a place in surgery, both from its uncertainty and from the danger of hæmorrhage and perforation; moreover, the relief given by the operation can only be of a very temporary nature.

GASTRIC ULCER.

Passing over malignant, tuberculous, and syphilitic ulcers, the special form of ulcer which produces the complication calling for surgical treatment is the simple ulcer of Cruveilhier, which may be classified according to its stage and size, and to this may be added the simple erosion of the mucous membrane described by Dieulafoy which at times leads to serious or even fatal hæmorrhage. There appear, however, to be clinically two distinct forms of ulceration of the stomach—the acute and chronic; but although they seem to be separate and characteristic there are so many intermediate stages that it is a question whether or not the ulcers are as distinct as the extreme varieties would seem to indicate.

Complications.—Although the following complica-

tions are common to both forms of ulcer certain of them are much more common in one than the other. For instance, the acute round ulcer is more frequently followed by violent hæmorrhage and by perforation than the chronic ulcer, yet the chronic ulcer is also liable to be followed by both. On the other hand, the chronic ulcer is more frequently followed by cicatricial contraction of the pylorus with subsequent dilatation of the stomach and by perigastritis leading to disabling adhesions, also by hour glass contraction, fistula, and tumour of the pylorus or of the stomach, serious atonic motor deficiency, severe gastralgia with uncontrollable vomiting, cancer of the pylorus, tetany, chronic pancreatitis, abscess of the liver, chronic hepatitis, profound anæmia (resembling the pernicious form), stricture of the bile-ducts, jaundice, catarrh of the gall-bladder, and other complications depending on invasion of the neighbouring organs. Both forms are accompanied by pain, by great loss of flesh and strength, and at times by subphrenic abscess. It will be at once perceived that surgery is intimately concerned with and is in fact the only effectual treatment in many of these complications, some of which I propose to treat in detail.

Diagnosis.—The well-known symptoms of pain after food with vomiting and bleeding as shown by hæmatemesis and melæna are usually sufficiently characteristic of gastric ulcer, and in the present lectures it is not necessary that I should enter very minutely into the question; but no surgeon can afford to pass over the diagnosis, which he must confirm personally before deciding on the question of surgical treatment. The diagnosis between gall-stones and ulcer will usually be indicated by the irregularity of the paroxysms of pain, which in gall-stone colic occur quite independent of food, by the character and site of the pain, the presence of jaundice and the character of the vomiting, which in cholelithiasis usually comes on soon after the pain begins and persists long after all food has been rejected. To diagnose between ulcer of the duodenum and ulcer of the stomach, the occurrence of the former more frequently in men and after middle age, the presence of melæna with or without hæmatemesis, the pain occurring from an hour to two hours after food and the tenderness on the right of the abdomen will usually be sufficiently characteristic.

I would here point out as bearing on the site of the ulcer the importance of the character and site of the pain, which in an ulcer of the stomach is usually definitely localised and associated with tenderness on pressure. The tender area is in the upper abdominal region, the position being more or less to the right or left of the middle line, according to the site of the ulcer.

With regard to hæmatemesis, which is said to occur in about 80 per cent. of cases of gastric ulcer, and melæna, which is usually associated with ulcer, but sometimes occurs without hæmatemesis, they will be considered later, for hæmorrhage is one of the important complications on which the mind of the profession, so far as treatment is concerned, is not yet by any means crystallised. Latent ulcers are not uncommon. It is difficult to explain why some of these ulcers should exist without producing symptoms until either perforation or violent hæmorrhage occurs. In the cases I have seen the ulcer has been near the lesser curvature of the stomach, and this might possibly afford an explanation, as in this situation they would be brought less intimately in contact with food.

TREATMENT OF GASTRIC ULCERS.

The surgical treatment of intractable ulcer of the stomach is still *sub judice*. Besides excision and gastro-enterostomy, pyloroplasty, pylorodiosis, and pylorectomy have all been employed in the radical treatment of gastric ulcer, but the latter operation

only where pyloric contraction with tumour had developed.

The question will have to be finally settled by a careful study of statistics, and to this end I have, with the assistance of Mr. Willmott Evans, collected 188 cases of gastric ulcer treated surgically. Of this number 157 recovered and 31 died, thus giving a mortality of 16.4 per cent. My own experience and a careful study of the subject would lead me to say that the time has not yet come for a sweeping change to be made in the treatment of uncomplicated gastric ulcer except in the way of more rigid and more prolonged medical treatment, but that when the ulcers prove intractable, or when complications supervene, medical treatment should give place to surgical treatment at a much earlier stage than has hitherto been the custom.

I have operated on 34 cases of intractable gastric ulcer with various complications which in every case must have caused permanent disability or would have ended fatally, but excluding perforation, hæmorrhage, and cancer, all of which I am considering separately. Of these, 18 operations were done in private with one death, giving a mortality of 5.5 per cent., and 16 in hospital with five deaths, giving a mortality of 31.2 per cent., or if both private and hospital cases be taken together the mortality is 17.6 per cent.

The conclusions that I would urge concerning the surgical treatment of gastric ulcer are the following: 1. In all cases of gastric ulcer, except in case of perforation, medical treatment should be first tried. 2. Where ulceration persists or the symptoms recur and prove intractable to medical treatment gastro-enterostomy should be performed so as not only to give rest to the stomach but to relieve the hyperacidity of the gastric juice. 3. As a rule, direct treatment of the ulcers by excision is unnecessary. 4. Complications, such as adhesions, pyloric contraction, dilatation, and hour-glass contraction, leading to loss of flesh and impairment of health, should be treated surgically. 5. In chronic hæmorrhage surgical treatment is advisable, as it is in some cases of recurrent acute hæmorrhage, but, as a rule, acute hæmorrhages should be treated medically. 6. In perforation surgical treatment is demanded.

SURGICAL TREATMENT OF HÆMORRHAGE DUE TO ULCER.

This is a question which one cannot too carefully consider, and although statistics are apt to be misleading, it is a subject in which statistical evidence is manifestly worth careful consideration. The average gives approximately 5 per cent., which seems to be a proportion agreed on by English physicians.

Doubtless the desirability of stopping bleeding from an ulcer of the stomach by surgical means must have occurred to many minds before being put into execution. To Mikulicz, however, belongs the claim of having been the first to operate for hæmorrhage from a gastric ulcer.

Of the 15 cases reported by Mikulicz, in 5 cases the ulcer was not discovered, in 2 cases it was excised, in 1 case the pylorus was resected, and in another case the ulcer was cauterised. Petersen has reported from the Heidelberg Clinic 6 cases of hæmorrhage cured by operation, 2 cases by excision of the ulcer, and 1 case by gastro-enterostomy. Hartmann collected 12 cases, with 8 deaths and 4 recoveries. Nearly all the deaths occurred from collapse. Besides the contra-indication to operation in acute hæmorrhage, advanced age, poor general condition of the patient, and excessive anæmia would seem to be contra-indications.

In acute hæmorrhages the mortality is very high; 27 died and 15 recovered in 42 cases, which gives a mortality of 64.2 per cent. On the other hand, in

the chronic hæmorrhages out of 19 cases 2 died, giving a mortality of 10·5 per cent.

In considering the question of operative treatment for supposed hæmorrhage from the stomach it is well to bear in mind that bleeding may occur from the following causes: (1) from retarded circulation, as in cirrhosis of the liver and heart disease; (2) from aneurysm of the aorta and celiac axis; (3) from miliary aneurysms in the stomach; (4) from erosion of a vessel by ulceration due to a biliary calculus, as in a case reported by myself; and (5) from vicarious menstruation. The operative measures that may be employed in the treatment of hæmatemesis from bleeding ulcer are (1) excision of ulcer; (2) pylorotomy; (3) cauterisation of the ulcer; (4) ligation of the ulcer and vessels *en masse*; (5) ligation of the bleeding vessels *in situ*; (6) scraping of the ulcer followed by suture of the ulcerated surface; (7) ligation in their continuity of the large vessels supplying the ulcer; and (8) gastro-enterostomy. After gastro-enterostomy as a rule all symptoms disappear at once and hyperacidity ceases owing to the unobstructed escape of the gastric contents.

OPERATION FOR BLEEDING ULCER.

On account of the fear of exciting fresh hæmorrhage it is undesirable to wash out the stomach before operating on a bleeding ulcer, and as the patient is usually anæmic and will therefore bear shock badly it is desirable to have him enveloped in cotton wool or otherwise kept warm on a heated table and to give a subcutaneous injection of strychnine before operation. If it be unnecessary to give an infusion of saline fluid before the operation an assistant should be ready to perform that duty while the abdominal operation is being proceeded with, should it be called for. After the abdomen is opened the stomach may be emptied by pressing the contents into the duodenum as suggested by M. Terrier. This saves much time, and rapidity is of great importance. The surface of the stomach should then be carefully examined, as very frequently a puckering of the surface or a thickening of the coats will be noticed at the site of the ulcer, or a difference in colour may sometimes indicate its site. Should the operator be fortunately able to find these indications, much time may be saved, but if no indications of this sort be obtained, the stomach must be well drawn forward and opened either by a vertical incision, which gives less hæmorrhage, or by an incision in the long axis of the stomach, which affords a much better view of the interior. In order to avoid soiling the peritoneum, thin flat sponges should be placed within the abdomen, and it is well to have a perforated sterilised gauze pad covering the stomach, the opening to correspond with the opening in the stomach. The edges of the stomach should then be held open by forceps, one above and below and one at each end.

The interior of the stomach must now be systematically examined, first the anterior and posterior surfaces, the upper and lower curvatures, and lastly, the pyloric and cardiac orifices, all of which can be done either by the naked eye or by the aid of an electric cystoscope or a reflected light. If the posterior wall of the stomach cannot be efficiently examined, a slit may be made in the omentum, and two fingers, or even the whole hand, pushed through it and employed to invaginate the posterior wall. If no ulcer can be found on the wall of the stomach the duodenum should be explored, not only by the finger, but by invagination. If no ulcer be found anywhere and the bleeding proves to be capillary or from small undiscoverable ulcers, gastro-enterostomy as advocated by Doyen should be performed, but if an ulcer be discovered and it be possible to excise it, that operation should be done, as it undoubtedly offers the likeliest method of cure. After excision of the ulcer and liga-

ture of the bleeding vessels the edges of the wound are brought together by sutures, of which one or two layers may be employed. Should the excision involve the peritoneal coat it is desirable if possible to apply Lembert's sutures, and if it be on the posterior wall the operation may present some, though not insuperable, difficulty. Should the ulcer be discovered in some region where excision is impracticable—for instance, near the cardiac end—the method adopted by Mikulicz, in his first operation in 1887, of applying the cautery may be employed. This seems to have answered well in several cases, and where death occurred afterwards it was not from a recurrence of the bleeding. Possibly in a case of this kind gastro-enterostomy might also be advisable by way of setting the stomach at rest, or the ulcer might be curetted; but in one case in which I simply scraped the ulcer and applied carbolic acid an extension of the ulcer occurred and led to perforation on the eighth day, so that I am not much in favour of trusting to curetting simply. If any superficial points of bleeding be discovered they may be caught up by forceps and ligatured, but this is more easily said than done, as the mucous membrane is very friable, and a ligature if drawn at all tightly tends to cut its way through; moreover, forceps easily tear the mucous membrane and may produce a larger bleeding area. A method of ligation may be employed if the ulcer is small. This has proved serviceable in several cases and is easy of application when the ulcer can be reached. This method of ligaturing *en masse* has been tested by experiments on animals by Dr. Eisendrath and has been shown to endanger perforation except when supported by external sutures. Ligation of the main arteries of the stomach was suggested theoretically by Savaraud, when no bleeding ulcer could be discovered; it does not, however, commend itself as being safe and it has not yet been put in practice.

Should the bleeding be from an ulcer at the pylorus the operation of pyloroplasty may be performed, the ulcer being excised, the edges of the ulcer being united so that the line of sutures shall be transverse to the axis of the pylorus. I would not, however, advise pyloroplasty when there is active ulceration of the pylorus unless the ulcer can be completely excised, for in three cases of this kind I have had disappointments. I think that in cases of ulcer of the pylorus, where a clean excision of the ulcer cannot be done, it would be better to perform gastro-enterostomy or pylorotomy, whichever at the time may appear to be easier. So far as I can gather, the mortality of pyloroplasty in simple ulcer appears to be about 13 per cent., that of gastro-enterostomy about 16 per cent., and that of pylorotomy 28 per cent., but it is most difficult to get at genuine statistics since many single failures are unreported, and these figures must only be accepted as approximate. Wherever the pylorus is adherent, as in my experience it is in so many cases of ulcer, I should certainly prefer gastro-enterostomy, but if the pylorus be extensively ulcerated and free from adhesions, pylorotomy can be almost as quickly performed as gastro-enterostomy, seeing that the pylorus is already in the hand. The operative treatment of parenchymatous or capillary hæmorrhage by any surgical method would seem to be of doubtful value, for according to a report by Petersen from Czerny's clinic of three cases operated upon for severe parenchymatous hæmorrhage from vicarious menstruation operation entirely failed to relieve, and of two other cases of post-operative parenchymatous hæmorrhage by Reichard both died.

After a careful study of reported cases as well as from personal experience I cannot help feeling that operative treatment in acute hæmorrhage gives such a high rate of mortality—64·2 per cent. as compared with from 5 per cent. to 10 per cent. in cases treated

medically—that it is better in such cases to rely solely on medical means. But in the repeated chronic hæmorrhages that are responsible for quite half the total deaths from hæmatemesis the operation of gastro-enterostomy affords a reliable method of treatment, since it at the same time gives rest to the stomach and removes the hyperacidity of the gastric juice by an operation that can be done with rapidity and comparative safety; moreover, when the ulceration is at the pylorus, where it so frequently leads to hypertrophy and stenosis, the operation not only relieves the symptoms for which it was undertaken but proves curative to the disease.

SOME CASES OF GYNÆCOLOGICAL SURGERY. (a)

By E. STANMORE BISHOP, F.R.C.S.,

Surgeon to the Ancoats Hospital, Manchester.

ACCURACY in diagnosis depends mainly upon the man who is examining, but however careful and accurate the observer, there remain some cases of abdominal surgery in which it would seem that it is only possible to reach a certain point before, and that the final diagnosis must be made either at or even after the operation. One learns more from one's own mistakes than from one's successes, and to others, the cases in which a fellow surgeon owns his limitations are always more interesting than those in which he was easily and obviously right from the commencement. I make no apology, therefore, for bringing before you my first three cases, which illustrate this point. The last two cases I show in order to bring up the question of comparatively early operation in uterine fibromyomata on which I am very anxious to elicit your opinions.

CASE I.—*Sclerocystic Ovary—History simulating Ectopic Pregnancy.*

Mrs. H., æt. 26, admitted October 18th, 1899; two years previously, June, 1897, had the right Fallopian tube removed for pyosalpinx. Recovered perfectly. After this, she remained in good health until July, 1899, when she began to vomit, chiefly in the morning, but more or less all day, for a fortnight. Her breasts began to swell and springe. About a week after, her menstrual period came on. This was at the proper time, but was much more than usual, and lasted six days. It was accompanied by expulsive "labour-like" pains. This has recurred with each succeeding period. The blood was passed in clots. When these passed the pain became easier. After the period in July, there was leucorrhœa persistently stained with blood until the next in August, which was somewhat less painful, and lasted three days. This was again followed by leucorrhœa until the next period in September. This period began and continued for one day, ceased for one day, and then returned for another twenty-four hours. With this period there was much more pain and vomiting than before. Shreds of membrane are said to have been passed on this occasion. Since the last period, October 5th, she has been vomiting after nearly all food taken.

There is persistent pain in the left inguinal region, increased on micturition and defæcation. The abdomen is full, but not distended. There has been some pain over epigastrium for many years, but this is increased since the commencement of the present illness. The breasts are flabby, nipples have brown areolæ, with one or two follicles. Patient believes herself pregnant. The uterus is normal size and

mobile. The right broad ligament is clear. On the left side is an elastic swelling, separable from the uterus, but attached to the broad ligament. It is approximately the size of an egg. Diagnosis was ectopic pregnancy. On the 20th of October abdominal section was performed in the Trendelenburg position. There were a few fine adhesions, easily separated, and two stronger but narrow bands attaching the mass respectively to the omentum and small intestine. These were tied and divided. The swelling, consisting of the left tube and ovary, was first separated from the uterine end, which was free for about one centimetre. The tube passed over and encircled the main mass. The whole was easily removed, not being firmly adherent to the broad ligament. The abdomen was closed by tier suture without drainage. Perfect recovery.

At the time of her next period, however, there was some pain on her left side, lasting two days, similar to that felt before ordinary menstruation, easily relieved by manganese, and which did not return.

Examination of the specimen at first appeared to confirm the diagnosis. An outer coat of moderate toughness, about 2 mm. thick, smooth externally, but villous internally, was incised, and turned up. It was free for about half its internal circumference. To the rest was intimately attached a fine transparent membrane, over which minute vessels ramified. Between the two projected the edge of a dark red substance, which suggested placenta.

When, however, the finer membrane was cut through, the cavity exposed contained only about 5ij of a clear slightly albuminous fluid, in which floated a small tag of fatty membrane, depending from a narrow attachment to the upper part of the cyst wall, at a point some distance away from what we had taken to be placenta. Microscopic examination of the wall of the cyst at various points disclosed no amniotic or chorionic structures, but the sections were simply through tubal and ovarian structures.

The explanation which to my mind appears most probable is, that the previous inflammatory condition in the pelvis had produced firm adhesions between the tube and ovary. When later, cystic changes commenced in the ovary, the normal dilatation which would otherwise have occurred painlessly was obstructed by these adhesions. The hydrostatic force exerted upon these by the dilating cyst produced the sympathetic irritation, leading to the evolution of all the symptoms which misled us.

CASE II.—*Double Papilloma of Broad Ligament.*

Mrs. L., æt. 40, three children, no miscarriages, menstruation always painful before, pain passing off when flow established. Periods regular up to time of fall, since have occurred every fourteen days. Sent to me by Dr. Knapton, of Manchester, in 1898. A very stout woman. She presented a greatly enlarged and distended abdomen, which, when I saw her, contained evident free fluid. Dr. Knapton, who had watched the case for several months, was, however, confident that at first this fluid had been contained in a capsule of some kind. He diagnosed an ovarian cyst, springing from the left ovary. In the middle of August, 1898, she tripped at the top of the stairs, and fell heavily on to the floor of the hall beneath. Acute pain was produced at once, and the size of the abdomen very rapidly increased. He believed, and so did I, that the ovarian sac burst at this time, the fluid becoming free in the abdominal cavity. She was tapped by me on November 21st, 1898, when 3½ gallons of perfectly clear, yellow gelatinous fluid escaped. This confirmed our diagnosis. She was taken into a surgical home, and abdominal section performed, November 30th, 1898. A large amount, several gallons, of this clear fluid was evacuated. You will note the length of time which had elapsed since the

(a) Read before British Gynæcological Society, March 8th, 1900.

injury, at which we presumed rupture of the cyst had taken place. The peritoneum was perfectly healthy, but springing from the left broad ligament was this mass, which appeared to be the sac completely inverted and presenting a reddened villous surface to the peritoneal cavity, instead of the usual pearly-white smooth surface which, in this case, appeared as if inside the mass. The patient recovered rapidly and was perfectly well for some six months.

Were we right in our explanation of the sequence of events and the appearances presented on opening the abdomen? If so, the after history is difficult to understand. In August, 1899, she again began to enlarge. This time the point of departure and the locality of most pain was the right inguinal and iliac region. Enlargement was more rapid than on the previous occasion, her circumference at the umbilicus measuring 53 ins., and she was again operated on in the same way by abdominal section on November 2nd, 1899. On opening the peritoneum, once more the same clear, yellow, gelatinous fluid made its appearance and gushed out in great quantity. Several gallons were collected, but a large quantity besides escaped. On the right side, springing from the right broad ligament was precisely a similar mass to the one previously removed, and which I show. The ovary was found distinct from, and just by the side of this. No other mass was found in the abdomen, except a small growth which might have formed part of this mass, and become adherent to the back of the uterus. At all events it was closely adherent to the organ, and appeared to come away separately. One coil of small intestine was reddened and somewhat villous looking, but the left broad ligament, from which the original growth was removed was normal, and the rest of the peritoneum as far as could be seen, was the same. The abdominal cavity was washed out with saline solution until it returned clear, closed by tier suture, sealed with celloidin. No drainage. Perfect recovery.

It seems difficult to imagine that two cysts springing from opposite ligamenta lata should become inverted, since there was no accident this second time to account, as the first appeared to do, for such an incident. On the other hand, if as I am disposed to believe, both these growths are papillomata, it is curious that the neoplasm did not recur at the seat of its previous ablation, but at the corresponding point on the opposite side, and that it grew to this size without apparently affecting the rest of the peritoneum.

Such papillomata are recorded by various writers, and they appear to hold a position midway between malignant and simple growths. Knowsley Thornton had a case which had remained free from relapse nine years at the date of publication. Lomer records a case in which two such tumours were removed, the size of both fists, leaving secondary excrescences scattered over the intestines, and the parietal peritoneum, yet four-and-a-half years after there had been no sign of return. Kelly, however, records a case, which improved greatly after a tentative operation, which had to be abandoned owing to the wide generalisation of the growth, but died three years later, with the disease in an advanced state.

Pfannanstiel found sixty papillomata in 400 cases of ovariectomy; of these, twenty-nine were bilateral, and twenty-six located only on one side.

Most of the cases recorded are cystic papillomata, the papillary growth occurring on the inside of cysts, or growing through the walls of such cysts. It will be noted that in this case, at all events in the second growth, there is no evidence of any such capsule, the growth being of the shape and character of an enormous mushroom, springing from the edge of the broad ligament, its origin occupying the site of the Fallopian tube, which was not seen. Kelly figures

a similar condition on one side, a series of mulberry masses hanging from a delicate pedicle attached to the Fallopian tube.

Bland Sutton figures a similar mass, which he calls a ruptured papillomatous paroöphoritic cyst of the ovary, but he says that not all such papillomatous growths in this situation arise from the paroöphoron. The second tumour removed apparently had no connection with the ovary at all. This organ was lying by its side and external to it.

Penrose says that the most popular view among American and English pathologists is that papillomatous cysts originate from remains of the Wolffian body. Coblenz says that they arise from the medullary tubules of Kolliker.

By the kindness of Dr. Fothergill I am able to show sections of the second growth and of the ovaries.

CASE III.—*Large Pyosalpinx, the Symptoms of which simulated Appendicitis.*

Mrs. O.L., æt. 28, married seven years. No children or miscarriages. Admitted January 24th, 1900. Does not admit having suffered in any way since marriage. No discharge, no pain or smarting on urination. Says that her husband is perfectly well and always has been. Menstruation has always been regular, with an occasional intermenstrual period of five weeks.

Fourteen days before admission she was suddenly attacked with pain in the right iliac region. This pain was increased by pressure upon a point somewhat below McBurney's point. There was some vomiting, and constipation, but she has always been constipated. Dullness on percussion extends upwards from Ponpart's ligament to beyond the umbilicus and median line. Skin tender, not cedematous.

Patient is very stout, alcoholic appearance. Colour florid. Lies on her back with her knees drawn up. Complains of intense pain in the lower abdomen, Worst on the right side. Temperature 102 degs. Was seen by two physicians, who diagnosed appendicitis.

January 24th.—Under chloroform the mass was felt to be large and too closely connected with the uterus to be due to appendical abscess. Besides, its outer limits could be defined. It was therefore diagnosed as pyosalpinx. It was too high up and fixed for vaginal removal.

Abdominal section was performed in the Trendelenburg position. A large opening, passing to the left for 2 ins. above the umbilicus was made just outside the central line. The omentum was found firmly adherent to a tense, elastic mass behind, and to the right of the uterus. This was tied and divided in front. An attempt was then made to lift up the mass, but in doing so some thickened omentum which had been plugging the fimbriated extremity of the dilated tube, tore away, and pus, thin and ichorous, escaped. The sac was allowed to empty itself on to sponges, and then separation was begun from the uterine side. The uterus was normal in size. The tube at its point of exit from the uterus was the size of a male adult thumb; was closely and firmly adherent to the side of the uterus and broad ligament. When all was freed, the mass was turned out, and proved to be a tubo-ovarian abscess, the size of a small cocoanut, springing from the right side. On the left, a fluctuant mass the size of a small intestine, and somewhat resembling it, was freed from numerous adhesions and removed. This was the left tube and with it was a cystic ovary. There were many long membranous adhesions attached to the bowel, uterus, and other organs, and these were tied and removed. The abdominal cavity was dried out and closed; as the cavum Retzii had been widely opened during the various manipulations, a small drainage tube was left in it, and removed in forty-eight hours. It is very

doubtful if the parietal peritoneum was not soiled by some of the pus, and a good deal of evidently infected omentum was removed. After the operation the patient was very restless and in pain, requiring $\frac{1}{4}$ gr. hypomorphia.

Calomel was commenced four hours afterwards 3 grs. at first, repeated every hour for three doses. There was considerable hiccough for thirty-six hours. Recovery was delayed by a sharp attack of bronchitis, and a little suppuration in the abdominal wound, but there was no peritonitis, and she perfectly recovered at last.

CASE IV.—*Sloughing Fibromyoma.*

(Sent by Dr. Parkinson.)

Mrs. T., æt. 65, married 43 years, seven children, youngest 27 years; very severe confinements, always required forceps; last confinement complicated with placenta prævia; two miscarriages. There has never been any definite menopause; was regular up to 60; irregular discharge of blood since. She has lost blood more or less constantly for the last four years. Eight years ago an intra-uterine polypus was removed by another surgeon. Has had some offensive smell for about five years. In August, 1898, there was a very great loss of blood mixed with very offensive material. Bleeding has been more in quantity lately. Has lost appetite and flesh for some time. Nothing in family history.

April 19th, 1899.—Patient is shrunk, with flabby tissues, looking fully her age. Vulva is excoriated by watery discharges from the vagina; these discharges smell most foully and suggest the odour of carcinoma.

Os uteri is widely dilated; discharge issuing from uterine canal is cheesy, foul smelling, mixed with brownish watery fluid.

Recto-bimanual examination demonstrates a very large uterus with firm, hard, well-defined bosses. Uterus is mobile, both broad ligaments clear. Diagnosis, sloughing uterine fibromyoma.

Combined operation, commencing from below. The uterine canal was plugged with iodoform gauze, the lips of the os being sewn together over it. The bladder was separated for some distance, Douglas' pouch opened, and, the uterine arteries being tied, the lower segment of the broad ligament was separated from the uterus on both sides. In the Trendelenburg position the remaining separation was completed, but on seizing the uterus with Doyen's vulsellum forceps in order to lift it, the outer coat tore, giving exit to some putrid material. Fortunately, a large sponge behind the uterus prevented this from touching the peritoneum, and the operation being rapidly completed, the mass was removed. From the deeper portion of the broad ligament and the vaginal edges some rather persistent venous bleeding occurred, so that several forceps were required. As the patient was rapidly becoming collapsed, these were collected in a bunch, wrapped round with iodoform gauze, and left, projecting through the lower part of the abdominal wound, which was closed down to them, the gauze being previously drawn into the vagina, so as not to project into the abdomen, its upper extremity lying just below the level of the pelvic peritoneum. About four other forceps had been left on in the vagina; these were also wrapped in gauze, and the patient somewhat hurriedly transferred to bed, as the pulse was extremely low and thin.

After a short time she rallied, and in forty-eight hours the forceps were cautiously removed, the gauze being left for twenty-four hours longer. When this came away the track was covered by a dark, black, sloughy membrane. There was, however, no sign of peritonitis. The track which extended through from the abdominal wall to the vagina, was mopped with strong carbolic acid and dressed with glutol, and two

days later was gently irrigated with formalin solution. Under this the slough separated, leaving a clean granulating surface. Healing was delayed by a certain amount of suppuration in the subcutaneous layer of the wound, into which the same black slough spread, but after opening up the skin, washing out and dressing with glutol, this cleared up and the patient entirely recovered, although for some weeks she gave us considerable anxiety, there being great difficulty in feeding her and a strong tendency to syncope, but there was no peritonitis from first to last. She has, as was to be expected, some ventral hernia, but no sinus, and the hernia is easily controlled by a belt. She reports herself February 23rd, 1900, as greatly stronger than for years, but with some slight difficulty at times in retaining urine.

CASE V.—*Uterine Multiple Fibroma with Central Suppuration in one Mass, no Menorrhagia.*

(Sent by Dr. Dreschfeld.)

Mrs. H., æt. 40, married, three children, all severe confinements, instruments with all. Healthy looking woman. No menorrhagia. Sensation of weight, pain over coccyx, prolapse, nausea, and vomiting. Illness dates from birth of first child, nineteen years ago. Pain and sickness are intensified at the menstrual periods. Has worn a ring pessary for some years. This is shrivelled and offensive, and has produced some excoriation. Patient has become stouter, and rather breathless. Last period, January 9th, very slight amount. Defecation and urination easy, but amount of urine lessened. Examination shows an enlarged prolapsed uterus, very heavy, with hard rounded mass on the left side of fundus, and continuous with it.

January 19th, 1900.—Abdominal panhysterectomy in Trendelenburg position. Left ovary and tube adherent, tense, enlarged, forming one mass, removed with uterus. Right tube enlarged, lengthened considerably, right ovary apparently normal, both left. On removal of uterus, pelvic peritoneum united over gauze drawn into the vagina from above, by continuous suture, which turns all raw surfaces into vagina. Abdominal wall closed by tier suture, and sealed by celloidin. No peritoneal drainage.

The uterus, when cut open, showed two main masses, one subperitoneal, without secondary change, one interstitial and submucous. In the centre of this was a necrotic cavity, containing thick pus. This, I think, is interesting, as showing the preponderating influence of proximity to the mucous canal over vascular supply in determining necrotic changes. The patient made an uninterrupted recovery.

This case is brought forward in conjunction with Case IV., because there were in it none of the symptoms usually considered as justifying operative interference. There was no great loss of blood, no loss of health, anæmia, or emaciation, no rigors or other signs of septicæmia. She was not confined to bed, or even to the house, and yet there was present a sloughing fibroid, which would within a comparatively short time have burst into the uterine canal, and no one could doubt but that, when this occurred, all the symptoms, risks, and dangers present in Case IV. would have manifested themselves. By timely removal, these were avoided, and the patient preserved her health. Myomectomy would doubtless have removed the two largest masses, but after section of the uterus, numerous smaller masses were found developing, the presence of which was not detectable by touch or sight even after removal. These masses if left behind would, without doubt, have developed later, and necessitated further operative interference. Moreover, any attempt to remove this tumour except as a whole would have liberated pus, the infectiousness of which could only

at the time of operation have been a matter of conjecture. The position I wish to maintain is that, whilst some fibroids, such as those discovered by accident, having given rise to no symptoms whatever, are best ignored entirely; whenever a fibromyoma shows signs of growth, it is wisest to remove it and with it the organ in which it has developed—the uterus; the removal or otherwise of appendages to depend entirely upon their diseased or healthy condition.

INFANTILE INSANITY. (a)

By Dr. WALTER BERNARD,

Consulting and Visiting Physician to the Londonderry Lunatic Asylum.

THE importance of studying the science and art of influence in the peculiarly impressionable epoch of infant life, during the many-sided, rapid periods of evolution, has hitherto been practically disregarded. Here in our first lines of defence, it is not to the specialist we have to look for aids and for solving difficulties. Moreover, at this very starting point of life, leaders of thought, asylum doctors, and hospital teachers are not in daily touch with the groundwork of clinical domestic observations in the earliest months of existence. The family doctor alone is placed in the position for disciplining the faculties by his observed facts, and while engaged in this work, for the future culture of the world he elevates those who carry out his directions in mental sanitation, practical life, knowledge and truth. Besides, he holds the key to the family pedigree and ancestral history. His insight, extended experience and close observation, enable him, at this very early stage, before mental action and mentation are evolved, to control inherited conditions. Practitioners, who have so much in their power to make life physiological and real, can prove by illustrations to the families of the earth that the lower elemental parts, out of gear in the first few months of life, can be raised out of automatism while ascending the rounds of the ladder before the scholastic period. Directive impressions conveyed to the infant for controlling, coercing, limiting, and encouraging to obedience by well-timed laws will tend to blot out aimless movements. To show that laws educate at the cradle side of life, correctional movements become more steady, and give signs that a mental advance has already commenced. But unless we persevere in this, our first encouragement, we cannot hope to be rewarded. Efforts, though tedious and wearying, will promote interest as the non-national inherited instincts begin to fade away. As growth advances, complications we may expect, for slight physical ailments may call into action, especially when the body is not normal, mental predispositions. A nettle rash, a peripheral neuritis, as in herpes zoster, or transient congestion, so common in a fatigued or growing brain, may excite changes in disposition which have again to be remedied. Many children are deprived the chance of not committing suicide later on, or spending some time in gaol, or their lives in a lunatic asylum, because the parents are kept in ignorance. Let us safeguard the dangers by casting them into the mould, and at the onset of existence deal with the whole being, while with the assistance of the mother we build up the sound elements, and the abnormal, which underlie the normal functions, will degenerate. It should be sent forth to the world that those born with insane propensities can be made, by judicious training, not only able to take care of themselves, but good citizens, thereby proving to the

world at large that heredity is not an unsurmountable barrier. Through the want of practical knowledge and professional interest it is difficult to awaken those in power to this vital question which so much concerns the nation at large. Hitherto our efforts have been unsuccessful, but since Connolly's unanswerable arguments, which he sent forth so far back as 1862, facts have come out in a clearer light. And now, after so many years of effort, we hope the Dublin school will make some practical move in formulating rules of guidance. May I be permitted to suggest that this section call upon the Council of the Academy to take action in the framing of rules for the guidance of practitioners. A comprehensive scheme, without undue elaboration, would, as far as my experience goes, be a valuable guide to the family doctor, whose advice would be readily realised and accepted by level-headed mothers against this appalling, avoidable evil. Mothers, who before doctors and nurses are frequently the first to discover the mental and physical infantile defects, are most willing to receive instructions for eradicating what they often feel would very probably end in life-long regrets. On the following grounds we ask for help:—

1. Reformatory influences must commence at home.
2. That no rules have been framed, sent forth, or established for controlling the earliest forms of insanity at the onset of existence, and before the scholastic epoch.
3. That on *preventive principles* the earliest diagnosis of insanity in infant life is of vital importance to the patients, the friends, the nation, and the taxpayers; and
4. That the sequent instances of three generations have declared, by manifest examples, that if in the beginning of life attention be paid to peculiarities in early infancy, disordered states of the mental faculties can be blotted out, which, if unchecked, incur ruin, and bring a plague to the family and neighbourhood.

Though, on former occasions, I brought the subject before this Section, and other medical meetings, and though my paper to-night may be looked upon as a mere recital or rehearsal of what I had already brought forward, yet the question is of such vital importance that I feel it should not be allowed to drop. We should never lose sight of the fact that the great object of civilisation is the happiness of the people. To quote our own historian, Lecky, he says—"Its foundation is laid in *pure domestic life*, in commercial integrity, in a high standard of moral worth, in public worth, in simple habits, to courage, in uprightness, and a certain soundness and moderation of judgment which springs quite as much from character as from intellect."

Clinical Records.

A CASE OF ACUTE INFLAMMATION OF A SUB-PERITONEAL FIBROID IN A PATIENT FOUR MONTHS PREGNANT. (a)

By Dr. WALTER.

THE patient, æt. 30, and married seven months, was admitted into St. Mary's Hospital, Manchester, on January 9th, she was about four months pregnant, and had always enjoyed excellent health. Her periods had never been excessive, but were at times painful. Five days previously she had been seized with pain in the abdomen, on the left side, which gradually increased in severity, and morphia was administered hypodermically.

On admission a hard tumour was felt on the left side

(a) Abstract of paper read at the meeting of the Section of State Medicine, Royal Academy of Medicine in Ireland, February 16th, 1900.

(a) Shown before the British Gynecological Society, March 8th, 1900.

of the fundus uteri, and the lower half of the abdomen was tender on pressure. An exploratory incision was made on January 11th, and some blood-stained serum escaped from the abdomen. A sub-peritoneal fibroid was found attached to the left and front part of the fundus. It was the size of an orange, and was undergoing a process of self-enucleation, the peritoneal covering had been ruptured, and the portion still embedded in the muscular wall of the uterus was attached by fibres undergoing necrotic change, and were easily separated by the finger. The bed of the tumour was sutured with fine silk; from one of the suture holes some free hæmorrhage escaped, but was controlled with a second suture.

The patient made a rapid recovery, and so far no miscarriage has occurred.

CASES OF SKIN DISEASE. (a)

By ALFRED EDDOWES, M.D.Ed.

THE first case is that of a girl presenting a single patch of lupus on the left side of the face, and a patch of impetigo on the opposite side. The lupus patch was smooth, free from "apple-jelly" nodules, and almost like normal skin in the centre, whereas at its margin it was spreading, and the disease was penetrating more deeply, having much the appearance of verruca necrogenica. I think it is a case of infection from without, primarily of the epidermis, and that the disease could easily have been cured by ointments had it been taken in hand earlier because the disease had been quite superficial, like an eczema. Now that the disease is deeper surgical treatment is required.

My second patient is suffering from lupus erythematosus of the scalp of twelve years' duration. Two perfectly symmetrical patches about 3 ins. long and nearly 2 ins. wide run vertically down the sides of the scalp about an inch behind the ears. Small portions only show hyperæmia and the characteristic horny plugging of the hair follicles, the rest being hairless and cicatrised. Erythematous areas which have appeared lately on the bridge of the nose and at scattered points on the cheeks indicate a tendency of the disease to develop in the more common "butterfly" form. Ointments as a rule do not agree with her. They seem, in fact, to irritate and make the parts feel hotter. Except in very cold weather I use lotions containing lead and a little spirit, giving quinine internally, and looking to the general health. I always advise patients to avoid exposure to great changes of temperature.

The third patient is a girl who is recovering from leucoderma. Three years ago her back was of a dull yellow colour with numerous white patches on it. The pigmentation of the whole back is now practically normal, almost all traces of the patches being lost. I attribute the good result mainly to treatment, and I have brought the case merely to support my statement at the last clinical meeting of the society that leucoderma is curable.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, MARCH 23RD, 1900.

SIR R. DOUGLAS POWELL, Bart., President, in the Chair.

A CASE IN WHICH THE ATTEMPT WAS MADE TO REMOVE A DERMOID TUMOUR WHICH, GROWING IN THE SPINAL CANAL, PRESSED UPON THE SPINAL CORD.

DR. HALE WHITE read this paper by himself and Mr. A. D. FRIPP. The patient, a man, at 26, who had been suffering from a very chronic form of Hodgkin's disease, was first seen by the authors with Mr. A. F. Wilson at the end of March, 1899. In the middle of January, 1899, the patient began to complain of loss of power in the legs. By the end of March there was complete paraplegia, no muscular wasting, the breathing was almost entirely diaphragmatic, the right hand was much stronger than the left, all forms of sensation were lost up to near the nipples, there was no

hyperæsthetic zone, there was severe pain shooting down both intercosto-humeral nerves and round the chest along the second intercostal, the lower limbs were spastically rigid, the knee-jerks and plantar reflexes were exaggerated, there was great superficial tenderness over the second, third, and fourth dorsal spines, there was incontinence of urine with cystitis and obstinate constipation with great distension of the abdomen. The pulse was 120 and the temperature generally about 101° F. There were no other signs pointing to caries and aneurysm. The diagnosis was that there was some collection of fluid or a new growth within the spinal canal, irritating the second dorsal nerve, and compressing the cord below it. There was no evidence that this was syphilitic nor that it was malignant. An exploratory laminectomy was performed, the second, third, and fourth dorsal arches being removed. A grey tumour upon the outer surface of the dura mater was exposed, which reached out of sight both above and below. Pieces of the growth were snipped away. He quickly rallied from the operation and the wound healed by first intention. The tumour proved upon microscopical examination to be a dermoid. The patient was seen again by the authors eight weeks later. The pulse and temperature were normal. There was slight and occasional voluntary movement in the legs. The exaggeration of the knee-jerks was less and the rigidity had disappeared. There was almost complete return of all forms of sensation down to the groins, but no improvement in the lower extremities. The radiating pains had disappeared. The chest moved better. The cystitis and incontinence had disappeared and the constipation and abdominal distension were less. There was a large bed sore on the sacrum and another on the buttock. Considerable as had been the improvement, it appeared to the authors that as much of the tumour had been left behind, and as the pressure symptoms were far from completely relieved, the only chance lay in a further attempt at complete removal. A second operation was performed. A large mass of the tumour was found to have grown backwards through the gap in the spinal canal made at the first operation. The first, fifth, and sixth dorsal laminae were removed, but still no limit could be seen to the growth. The patient again rallied well, but sank eight hours after the operation.

The PRESIDENT remarked that the case was of considerable interest as bearing on the question how far interference was justifiable in cases of this kind.

In reply to the President, Dr. HALE WHITE said the case was unique as regards the nature, though not as to the position, of the tumour. Cases of dermoid cysts had been recorded in the middle line between the skin and the spine, but not within the spinal canal.

THE REDUCTION OF THE DEFORMITY OF SPINAL CARIES.

MR. ROBERT JONES (Liverpool) and Mr. A. H. TUBBY brought forward a report of ninety-nine cases of angular deformity from Pott's disease treated by manual rectification, including the results of the twenty-five cases brought before the Society in November, 1897. They recalled that the objects of that preliminary communication were to emphasise the following points:—(1) That rectification of the deformity was not *per se* an immediate danger to life; (2) that the operation did not necessarily cause paraplegia; and (3) that by pressure many curvatures could be lessened and even obliterated. In this first series of twenty-five cases the following results had been obtained:—5 had died, 4 had discontinued treatment, 15 were alive and well and walking, and one was recumbent and sickly. *Causes of death*: One died of vomiting four days after operation, but post mortem nothing was found abnormally beyond some enlarged mesenteric glands; one died of tabes mesenterica fifteen months after, one died of pulmonary tubercle sixteen months after last stretching, one of intestinal obstruction twelve months after, and one of diphtheria. Billroth, Menzel, Jaffé, and Mohr estimated the death-rate from Pott's disease to be 25 per cent., the authors' own death-rate being only 12 per cent. Four of the cases developed abscess, of which two healed and one became paraplegic eight months after operation, but had since recovered. Five of the twenty-five recovered

(a) Read at the Harveian Society, March 15th, 1900.

from paraplegia as the immediate result of the operation, recurrence taking place in one. In five the curvature was practically obliterated, and remains so with a spinal support, and the curve was much improved in ten. In a parallel series of non-rectified cases three had died of tubercle, four had developed abscess, two of them healing; four had become paraplegic, with two recoveries; and in seven the deformity was very marked. The authors then brought forward a series of seventy-four subsequent operated cases. Of these seven had died; twenty-nine were walking; twenty eight were recumbent; and ten had discontinued treatment. *Causes of death:* One died of empyema four weeks after operation; one died of general tuberculosis thirteen days after operation, and another two years after; one died of pulmonary phthisis eighteen months later, and one of pneumonia two years after; one died of exhaustion, and one died six months after reduction for paraplegia, without relief, of diarrhoea one month after subsequent laminectomy. Three were operated while abscess was present; thirteen developed abscess subsequently, of which nine had healed; seven cases had recovered from paraplegia, or it had been relieved, and remained well; in thirty-eight the curvature had been lessened, and remained so; in sixteen the curvature had either not improved or had become worse, but not necessarily as the result of the operation. The authors deprecated the employment of much force, their plan having been to proceed by stages with an interval of a month between each attempt. They laid it down that the after-treatment should not be less than three years. *Conclusions:* (1) That danger to life was not great, (2) that, far from inducing paraplegia, the operation was actually a curative measure, (3) that abscess formation was, if anything, less frequent; (4) that the risk of disseminating tubercle was a negligible quantity, (5) that there was no risk of a flail-like spine. *Contra-indications:* Cervical and high dorsal curves, unless associated with paralysis, (2) ankylosed spines, (3) large and angular deformities, (4) evidence of tubercle elsewhere, (5) in children under 2 and in adults over 2, (6) in presence of abscess unless there were paraplegia. They advised the operation only when the spine is yielding and in comparatively strong children free from abscess and tubercle. They pointed out that the operation was not to obliterate all the prominence, but to give as erect a position as possible. Lastly, they urged that cases for operation must be selected with great care, that personal care of the patients must be unremitting, and that fresh air was an all-important factor in the after treatment. They exhibited a selection of the first series of twenty-five patients brought from all parts of the country in order that Fellows might see for themselves the actual results.

The PRESIDENT observed that whatever they might think of the ultimate results of the treatment the facts brought before them must materially alter many of their present views. He asked whether albuminuria due to myeloid disease had disappeared when the surgical deformity was remedied.

Mr. JACKSON CLARKE said that in order to judge the results obtained in the cases brought before the Society, it was necessary to recall the treatment employed by the authors of the paper previous to their adopting the method under discussion. Mr. Tubby had said that up to 1896 he had chiefly employed corsets of plaster or of felt. Mr. Clarke had found that the results of this mode of treatment was very disappointing. Mr. Jones had put it on record that he had chiefly used Thomas's cuirass. This, in Mr. Clarke's opinion, though a better appliance than any corset, had the defect of not lending itself to periodical readjustment in an improved position, nor to the addition of a headpiece to relieve the spine of some of the weight of the head in cervical and high dorsal cases. By the use of an apparatus which allowed of the two latter effects being obtained, he (Mr. Clarke) had obtained results which he thought compared favourably with the cases before the meeting, e.g., in cases of lumbar deformity he had succeeded in obliterating an angular projection, and in other parts of the spine the deformity had been considerably diminished.

The death-rate of 25 per cent. quoted by the authors as given by Billroth in cases of tubercle of the spine was, he considered, by far too high. Even that of 12 per cent. obtained by Messrs. Jones and Tubby in the cases they had operated on was higher than that he himself had observed in his cases. The numerous contra-indications to operation given by the authors narrowed its scope so much that his own view of the matter was confirmed, namely, that forcible correction was a proceeding only called for in exceptional cases, the chief indication being paraplegia that had resisted a patient trial of milder measures.

Mr. BARWELL questioned whether the good done was as great as they were asked to believe, and he questioned whether there had been actual straightening in many of the cases of angular curve. On the whole he did not think that the results were better than would be obtained in three years by other methods of treatment. He observed that in the case of a child who was said to have had paraplegia the child was under two years of age at the time, and possibly was unable to walk, moreover the mother said the child moved his legs. He pointed out that by lifting the patient by the arms and watching the angle it was easy to see whether the ulcer of the bones had healed. On the whole he thought the results were somewhat disappointing.

Mr. BERNARD ROTH said that since seeing these cases he thought there was more in the treatment than he had imagined, but he would like to see the cases a year after all instruments had been left off.

Dr. PATON asked how long the patients remained in hospital under treatment, and he pointed out that prolonged recumbency in the homes of the poor could not possibly be a desirable thing.

Mr. HOWARD MARSH commended the authors for the vast amount of patience and labour they had devoted to the subject. They must however, all feel that the subject had not been thoroughly threshed out, though many interesting points had been raised, and he thought the question was one that might advantageously be referred to a committee for investigation and report. He was tempted to raise the question whether the authors' conclusions were justified by the facts they had brought forward. He challenged the estimate of 25 per cent. as the probable death-rate from Pott's disease. He himself would put it at 5 or 6 per cent. He pointed out that paraplegia was equally recovered from under other methods of treatment, and he concurred in the view that the correction of the deformity was often more apparent than real.

Mr. BERNARD ROTH seconded the reference to a committee.

The PRESIDENT thought a standing committee might serve a useful purpose, if only to separate the cases in which the operation was desirable from those in which it was not.

Some discussion ensued as to the scope of the reference and the way in which the inquiry could be carried out. Ultimately the proposal to nominate a committee was agreed to, the precise terms of the reference to be drafted by the Council.

Mr. TUBBY, in reply, said he thought it would be conceded that they had done their best to fulfil their pledge of two years ago to follow up these cases. He pointed out that they did not insist so much upon the value of the operation in remedying the curve. With reference to albuminuria he said it disappeared when the abscess ceased discharging and no patient had died of lardaceous disease. He did not believe that equally good results could be obtained with instruments. In reply to Mr. Barwell he said that the child stated to have paraplegia had the lower limbs rigid, with exaggerated reflexes and could not walk. He added that the labour, difficulty, and anxiety entailed by the endeavour to afford the Society such a demonstration of results as that before them were very great, and he did not think they could in any way manage to approve of a committee being sent about the country to inspect their cases, but the committee would, of course, be welcome to examine the records.

BRITISH GYNÆCOLOGICAL SOCIETY.
MEETING HELD THURSDAY, MARCH 8TH, 1900.

The President, W. J. SMYLY, M.D., in the Chair.

SPECIMENS.

MR. E. STANMORE BISHOP (Manchester) showed five specimens, of which an account will be found under "Original Communications."

DR. MANSELL-MOULLIN, speaking of the difficulty of diagnosis in Mr. Bishop's first case, pointed out that in many cases the diagnosis of extra-uterine gestation depends almost entirely on the statement of the patient; and the consequence was that no error arose more frequently than this one. In most cases where extra-uterine gestation was diagnosed the tumour was found to be a pyosalpinx. The error was, however, of no great importance, since the same treatment was required for both.

DR. C. H. F. ROUTH said that in dealing with an abdominal tumour the conclusion was often come to that the swelling was solid or liquid; but the most conclusive test was generally omitted, which was this: that on listening with the stethoscope the sounds of the heart were not transmitted through a liquid tumour; whilst they were readily transmitted when the tumour was solid. The stethoscope ought, therefore, to be always used in making a diagnosis.

DR. MACNAUGHTON-JONES said that the most important point raised by Mr. Stanmore Bishop was the question of early operation in the case of uterine myomata. It had been laid down as a surgical axiom, that if the risks attendant upon an operation were not in themselves greater than those arising out of the disease for which it was proposed to operate, then operation was advisable and justifiable. This appeared to him to be the issue in this instance. Were the risks from any given fibroid tumour greater than those arising from the operation in the case of the particular tumour on which it was proposed to operate? The present percentage of fatal results from supra-vaginal hysterectomy did not exceed in favourable hands from 5 to 8 per cent. When they came to consider the direct and indirect consequences of uterine fibroid, it would be seen that the risks arising from the disease were considerable. A certain number of patients contracted cardiac disease, a certain number died from ureteral and renal affections, another proportion succumbed from pelvic complication, some became affected by mental disease and dementia, and he instanced a case which he had lately seen where death occurred from anæmia and septicæmia, the consequences of hæmorrhage and necrosis of the tumour. Besides such constitutional conditions as these, there were many collateral troubles which deteriorated the health of a woman who suffered from fibroma. Of course there were tumours which gave rise to no troublesome symptoms, and which no one would operate upon and in which operation would not be justifiable, but in the case of a growing fibroid, and when the patient's life was threatened by any of the risks which he had mentioned, he thought that modern surgery emphatically declared itself in favour of operative interference.

MR. BOWREMAN JESSETT congratulated Mr. Bishop on his interesting series of cases. The question of the early removal of fibroids was one of the greatest importance. Dr. Champneys had lately written a paper in the *Lancet* deprecating the operation because of its high mortality, which he put down at 17 per cent. When he read Dr. Champneys' paper he was much surprised, because he thought the mortality was no more than 8 per cent. in skilled hands. It was, however, to be remembered, as was pointed out by Mr. Harrison Cripps, that some of the patients operated upon in St. Bartholomew's Hospital were already in *extremis*; such cases should not be included when estimating the mortality of the operation; but at least they supported Mr. Bishop's contention that myomata should be operated upon early. The mortality of the fibroids that were not operated upon was not known. For his own part, he advocated early operation. The question of age was of some importance; but if the patient were about to reach the menopause when the fibroid began to grow, this was an argument, not for

delay, but for early operation. Mr. Jessett then related two cases in which the patient would clearly have died if not operated upon. As to the choice of operation, there was a time when he advocated panhysterectomy; but he had now become a convert to supravaginal hysterectomy, performed in the manner first carried out in England by Dr. Heywood Smith.

DR. HERBERT SNOW said that he remembered seeing, about twenty years ago, a woman with a very large fibroid; it was recommended that the case should be watched. It was watched for six or seven years, and then the patient died. At that time the tumour weighed about 24 lbs., and death resulted from pressure. At the autopsy it was found that the tumour was attached to the pelvis all the way round, and it contained several foci of suppuraton. Such cases were an argument in favour of early removal.

MR. CHARLES RYALL, referring to Mr. Bishop's case in which forceps were left on, remarked that he had never left forceps on after a hysterectomy without regretting it. In one case he left a forceps projecting through the abdominal wound; the patient lingered on for two weeks and then died suddenly. At the post-mortem a gangrenous condition was found extending down from the abdominal wound to the situation of the cervix; it involved the bowel in several places. With regard to the early removal of myomata, it was to be borne in mind that two classes of cases were met with, those that needed operation, and those that did not. When a fibroid caused no trouble to the patient, it should not be operated on.

MR. CHRISTOPHER MARTIN (Birmingham) said that the question of early operation for myoma turned very largely on the risk of malignant changes supervening in these tumours. He had operated on a patient for uterine sarcoma, the history showing that she had for some time suffered from a myoma. She had been under observation during that time, but without presenting any symptoms calling for operation. As to the choice of operation, he preferred panhysterectomy, which he had first seen performed in 1894; and the results from this procedure in Birmingham had been so good that he did not think that they could be improved upon. He had up to the present time done thirty-five panhysterectomies with one death.

DR. WALTER (Manchester) thought that in this, as well as in many other operative procedures in which a great variance of opinion existed as to the question of operation, a middle course was the safest to adopt, and in the absence of symptoms an operation might be postponed unless the tumour were increasing in size. He believed that cases sometimes died from various chronic diseases which were not always recognised as the direct result of the pressure of the fibroid. He believed that a larger number of deaths occurred after the menopause, either directly or indirectly from the fibroma, than many suspected. He hoped such cases of neglect would not long continue, seeing that the mortality following hysterectomy among skilled operators was as low as 3 to 7 per cent.

DR. T. M. DOLAN (Halifax) said that the difficulty encountered by the general practitioners was that their patients came to London, where they found two widely diverging schools of thought: according to one school no operation at all should be done in any case of fibroid; according to the other school, nearly every case required operation. While this difference existed among the leaders of the profession, how could they expect the general practitioner to take a high position in the matter? To his mind one point was quite clear; if an artery were bleeding anywhere, the rule was to tie it, or at least arrest the hæmorrhage; and a similar rule should obtain in dealing with fibroids. They heard one eminent man say, "Wait for the change of life"; by the time this came about, the patient was probably moribund, and all that was left for the general practitioner to do was to sign the death certificate.

DR. J. INGLIS PARSONS remarked that the difficulty of the question was this: they would like to operate early on a fibroid that was going to become dangerous; but how were they to determine in the early stages which these cases were? The experience of years had not yet

told them. Then a distinction had to be drawn between hospital and private patients. Dr. Walter had given them one point of view about this; but, for his own part, he rather took the opposite position, namely, that a patient who had to earn her living was disabled from doing so if she had a fibroid; and so he would advise an operation in her case, whereas he would not advise it in the case of a private patient who could afford to be an invalid. He did not regard the possibility of malignant changes in a fibroid as a cogent reason for operating, because such a change was a rare occurrence. He had seen only one case among his hospital patients, and one in the charge of one of his colleagues. The position for them to adopt should be a middle one, between the man who would not touch any case of myoma, and the man who would operate on every one.

Dr. WALTER explained that his remarks referred to a working woman with a fibroid in an early stage, which did not interfere with her work.

The PRESIDENT believed that the mortality of operations for myoma depended not only on the dexterity of the surgeon, but also on his views of the question. One who believed that all cases should be operated on would probably have a mortality of 8 per cent.; one who held the views of Dr. Champneys would probably reach 18 to 20 per cent.; whilst a man who held an intermediate position like Dr. Walter would probably have a mortality somewhere between the two. As to the choice of operation, his own preference was for panhysterectomy; and he congratulated Mr. Christopher Martin on his brilliant results with this operation. It was found that the nearer they got to panhysterectomy in doing a supra-vaginal hysterectomy, the better. The mortality had fallen in proportion as more and more of the cervix had been removed. The objection that panhysterectomy was a tedious operation was answered by the rapidity of Doyen's operation. He had lately adopted Doyen's procedure with satisfaction.

Mr. STANMORE BISHOP, in reply, said that he was glad to have such a complete answer to the question he had proposed. The cases that needed no operation could be set aside, and, with regard to the other cases, it was evident that the position of the Society was quite against what had been lately expressed by some "leaders" of the profession. He wished to protest against the view that a fibroid tumour should necessarily be left till the menopause. He had lately gone the round of the museums in London; and the history of nearly every specimen was that the patient had been allowed to linger on till she was in *extremis*, then brought to the hospital, perhaps in a condition of sepsis, or quite exhausted, so that she was either too bad to be operated upon, or died at once after operation. It was not only a question of the great dangers incurred when no operation was done, but also of the greater risk attendant on the operation when it was at last performed.

Dr. MACNAUGHTON-JONES on a case of

CYST OF THE RIGHT MESO-SALPINX—THE TUMOUR LYING UPWARDS AND TO THE LEFT SIDE, WHILE THE OVARY WAS IN THE NORMAL POSITION, THE FALLOPIAN TUBE LYING FULL ACROSS THE POUCH OF DOUGLAS—COLPOTOMY AND CURETTAGE—RECOVERY.

The patient from whom these adnexa were removed was 21 years of age. She had been suffering pain from February, 1899. The catamenia were regular, but there was dysmenorrhœa. She met with an accident in the beginning of November 1899, falling from a height of six feet on to her back. Hæmaturia with pain on micturition followed the accident, and continued for some time. After the catamenial period in November she suffered from an attack which was regarded as one of peritonitis, but the pain passed off; she was married on December 2nd, ten days after the completion of the period. Three weeks subsequently pain again set in and continued on and off with more or less severity until I saw her on February 3rd. She was then suffering considerably. I found the right kidney somewhat enlarged and sensitive, and a pain in the course of the right ureter. There was a muco-purulent discharge from the vagina; the uterus was of normal size and somewhat fixed. A large, fluctuating swelling occupied the pouch of Douglas. The renal signs

and symptoms, the presence of the discharge, and the swelling in the pouch of Douglas, made me somewhat diffident as to a positive diagnosis. I hesitated between a pyo-salpinx or a possible early ectopic gestation with renal complications. On operating by posterior colpotomy the day after I saw her, I found the tumour lying mainly to the left side of the pouch of Douglas. The Fallopian tube lay right across, with the right ovary enlarged and cystic. The cyst, which was then about the size of an orange, was tapped of its clear fluid, and, with the ovary, was removed. Nothing abnormal was found at the left side. The patient had since had the uterus curetted, and has made a capital recovery. Mr. Targett, who examined the tumour, reports it to be a unilocular cyst in the meso-salpinx, having the relations of a parovarion cyst. Its wall is rugose and unevenly thickened, consisting of dense fibrous tissue lined with very short, or, in places, flattened, epithelium. It is difficult to account for the relative position of the ovary and the cyst.

He also showed a solid tumour of the ovary which filled the entire pelvis like a cast, the upper portion being cystomatous. The uterus had been pushed completely upwards, and out of the pelvis. The case had been diagnosed as one of uterine fibroma. This was natural, seeing that only the point of the cervix could be detected, and that it appeared to be one with the tumour. An attack of peritonitis led to the discovery of the tumour in December, 1899, since when it had grown rapidly. Mr. Targett would examine the tumour and report as to its nature. He was indebted to Dr. Allen, of Stanmore, for the case, and also for the following:—

"Large Fibroma of the Uterus Removed from a Patient on whom Operations had been Performed for Sarcoma of the Mammary Gland." The patient from whom the tumour was removed was forty-two years of age, and married. After a miscarriage nine years ago she suffered from pyo-nephritis, and as far back as that an enlarged uterus was detected. The interesting feature of the case was that within six years she had been operated upon eleven times for sarcoma of the mammary gland. The left breast had been amputated, the glands in the axilla and neck had been removed, as also several small growths about the left side of the thorax. For the last two years the patient had found the greatest difficulty in passing urine and in defæcation. He expected that possibly the tumour was sarcomatous. Microscopic examination by Mr. Targett proved it to be fibroma.

Dr. WILLIAM WALTER (Manchester) showed a specimen of a myoma, complicating pregnancy (see "Clinical Records.").

Mr. KEITH showed a fibrous tumour undergoing cystic degeneration which weighed 36 lbs. The growth had been removed from an elderly lady of 60 years of age. The history was, that ten years before, the presence of a fibroid tumour of the uterus had been diagnosed. It increased in size very slowly until eighteen months ago. About that time the growth began to increase rapidly, and when she was first seen, six weeks before operation, removal of the growth was advised. The operation was a comparatively simple one, the stitching of the wound taking up most of the forty-five minutes, as about forty deep stitches were required to close the wound completely.

ROYAL ACADEMY OF MEDICINE IN IRELAND. SECTION OF STATE MEDICINE.

MEETING HELD FRIDAY, FEBRUARY 16TH, 1900.

The President, SIR C. A. CAMERON, C.B., M.D., in the Chair.

SIR CHARLES CAMERON, C.B., on taking the chair, gave a short historical account of the origin of the Section. The Academy was formed in 1882 by the amalgamation of the Medical, Surgical, Pathological and Obstetrical Societies. At that time there was in existence a Society of Metropolitan Officers of Health, of which he had the honour of being President. The Society met monthly, and many valuable papers were read before them, and they had an annual dinner. He sug-

gested that, as the various Medical Societies were being amalgamated, it would be desirable that their Society should enter into the Union under the title of Section of Hygiene. There was considerable opposition to this proposal, on the grounds that it would unduly increase the number of sections, but ultimately the proposal was adopted in a modified form, and a Sub-section of Hygiene was constituted. The four Sections were each to have a President, but the Sub-section was to have only a Chairman. Some years subsequently the Sub-section was elevated to the dignity of a Section, and the Chairman was converted into President. He was the first Chairman, and now, after an interval of eighteen years, he again filled the highest office, under the title of President. Sir Charles then referred to several topics, including the notification of infectious diseases. He regretted that the Notification of Infectious Diseases Act was not a compulsory one, and he also regretted that so many medical men were opposed to notification. Measles and whooping-cough were not among the diseases enumerated in the schedule of the Act, but sanitary authorities had the power of adding them to the schedule with the assent of the Local Government Board. The Corporation of Dublin had included both diseases in the schedule, but whooping-cough had since been eliminated, as no good had resulted from notification of that disease. Measles was hardly notified in any town save Dublin, but he believed it was desirable that it should be notified. If the sanitary authorities in Ireland had the power of closing schools at the beginning of an epidemic (a power possessed by sanitary authorities in England), epidemics of measles might be checked earlier than they can now be. Notification of diarrhoea was required when these countries were threatened with cholera, but were only scheduled until all danger had passed away. Sir Charles referred to the inquiry now going on in London as regards the use of preservatives in food, and believed that some of them, such as boric acid, if used in moderation, would be useful. It would be better to consume food with a very moderate amount of preservative which kept the food fresh rather than food in a state of incipient decomposition, and containing deadly ptomaines.

Dr. W. BERNARD read a paper on "Infantile Insanity," an abstract whereof we published on page 319.

Dr. CONOLLY NORMAN said he had listened in vain for any practical suggestion from Dr. Bernard. A great deal was heard about "insane predisposition," and it should interest us all, for we all have it. It was a very short and obscure family which did not contain many lunatics. Dr. Bernard had employed another vague phrase in constant use, and to which it was difficult to attach any definite meaning—"judicial training." We were told lately that a British youth leaving a university had about as much education as an eight year-old German child. Which system was right?

Dr. SYMES said feeble-minded children were very different from idiotic children, but he thought we did not distinguish between the two classes in this country. He thought many of those charged with such offences as causing fires, &c., suffered from some mental defect. In the homes for children to which he was physician he divided all the children into the following six classes:—(1) Ordinary normal children, in health; (2) children physically but not mentally defective; (3) defective and feeble-minded children incapable of attending school; (4) epileptic children; (5) blind and deaf children; (6) idiots and imbeciles.

Dr. DAWSON agreed with Dr. Conolly Norman's remarks as to the excess to which the theory of heredity is carried now-a-days. No doubt in certain cases there would be no difficulty in making out a neurotic heredity, and in these cases prophylaxis should be employed if possible. He (Dr. Dawson) thought Dr. Symes had missed the point of Dr. Bernard's paper. Dr. Bernard had referred to extreme early infancy.

Dr. DOYLE thought self-control was the point needing greatest emphasis. He had seen very marked improvement effected in a case which had been sent to an institution in Holland where the patients are taken charge of

by farmers, and where no education is attempted, the patients being chiefly employed in manual labour.

Sir FRANCIS CRUISE thought Dr. Bernard's paper one of great importance in directing attention to the mental condition and proper mental training of children. He had seen children of two and three years of age whose mental condition pointed to insanity, and who ultimately proved to be insane. He was strongly convinced that a great many children are insane.

Dr. LITTLE hoped Dr. Bernard's paper was only a preface to a work on the subject. No advance would be made if they were content to deal with generalities. Undoubtedly, a great deal could be done in the training of children who had a tendency to grow up imbeciles. About fifteen years ago a boy came under his notice who was growing up an imbecile. He was sent to an institution near London, and is now an officer in the army.

Sir CHARLES CAMERON referred to the work being done by the London School Board in the training of children with impaired intellects. The children are examined by the medical officers of the Board, and special classes have been formed for the purpose of teaching those with mental defects.

Dr. BERNARD, replying, said the perceptive faculties do not begin to dawn until the dentition period, and the infant could be ruled and controlled in the same way as an animal. The moment the child is born the doctor should ascertain if it is physically normal. Then the cry, and the movements of the hands and legs, should be watched. Certain rules of guidance should be laid down for the mother and nurse, and so the infant automaton could be taught to observe order.

The Section then adjourned.

HARVEIAN SOCIETY OF LONDON.

MEETING HELD THURSDAY, MARCH 15TH, 1900.

Mr. W. H. LAMB, M.B., President, in the Chair.

CLINICAL EVENING.

The following cases were exhibited:—

MENINGITIS OF THREE MONTHS' DURATION—RECOVERY.

Dr. CAUTLEY showed a female baby who had recovered from a very prolonged attack of basal meningitis. The child was third in family, the others being healthy. She came under treatment on November 23rd, aged ten months, with a history of a measles rash on November 4th and a fall on the head on November 16th. Drowsiness, restlessness and irritability were noted on the day after the fall, and on the next day stiffness of the neck muscles, retraction of the neck with pain on movement, increased frequency of the pulse, fever and constipation. The course of the illness was characterised by the above symptoms, frequent vomiting, taches cérébrales, retracted abdomen, screaming attacks and a hectic kind of temperature ranging between 98 degs. F. and 104 degs. F. The child took food very badly and frequently had to be nasally fed. Double otitis media developed towards the end of December. There was no optic neuritis. For two months no improvement took place, but in the course of another month the fever and symptoms subsided, with temporary relapses, and after February 16th the temperature remained normal. During the illness the weight diminished from 14 lbs. 8 ozs. to 11 lbs. 5 ozs. It was rapidly regained when convalescent, a gain of 4 lbs. taking place in seventeen days. The child is now 15 lbs. 10 ozs. in weight, and is apparently quite well.

CONGENITAL INFANTILE PARAPLEGIA.

Dr. CAUTLEY also showed a boy of twenty-one months. He is the eighth child of a very healthy family, all the other children being alive and healthy. He was born at full time; labour being easy and not instrumental. He was entirely breast-fed for a year and partially so for another six months. Teething began at the eleventh month, and now eight teeth are cut. He was quite healthy until an attack of diarrhoea and vomiting, followed by a fit, last October. After Christmas he had bronchitis and varicella, and has been worse in every way since. At present he is a large and well-nourished

boy, with the exception of the lower limbs. These latter are small and ill-developed. The patellar and plantar reflexes are much exaggerated. He has never crawled, cannot stand, and raises himself with much difficulty into the sitting posture, which he maintains with ease. He appears mentally deficient. The weakness of the limbs was only noted in October, but has almost certainly been in existence since birth. There is not complete paralysis, for he moves the limbs freely when lying down. The case belongs to the group of paralytic affections included under the heading of congenital spastic paraplegia, and is of the variety in which no rigidity is present. It may be due to incomplete development or late development of the pyramidal tracts. Nothing indicates a past attack of encephalic or meningeal hæmorrhage. Some of the children thus affected, recover completely.

Dr. MACEVOY showed a boy, æt. 3½ years, suffering from Little's disease. Born prematurely with instruments; presentation was placental; suffered from severe rachitis between eight and fourteen months; could not sit up before eighteen months, or stand before 2½ years. His gait had been always since then typically spastic and ataxic. He frequently falls; rigidity present in legs, arms and neck (worse in former); plantar reflex gives extreme reaction; general development good; fairly intelligent; habits clean; no squint; no nystagmus; has never had convulsions. Dr. Macevoy was inclined to give the parents some hope that the child would improve up to a certain point.

Dr. W. CAUTLEY and Mr. J. JACKSON CLARKE took part in the discussion.

Dr. LEONARD GUTHRIE showed a lad, æt. 18, who in July, 1899, complained of "cramp" and shaking in his right arm, occurring after his day's work (bricklaying). He now has weakness with marked "intention" tremors of the right upper extremity, exaggerated knee-jerk and ankleclonus, but normal plantar reflex on the right side, recent and rapidly increasing double optic neuritis. His gait was awkward and shambling, but not reeling. Lately he had had attacks of vertical or right frontal headache, but no vomiting. Sensation and special senses were unaffected. The symptoms were regarded as due to tumour, either in the neighbourhood of the left optic thalamus, or in the right cerebellum.

Dr. WILFRED HARRIS showed a case of progressive muscular atrophy.

Dr. ALFRED EDDOWES showed several cases, notes of which are published under "Clinical Records."

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, March 24th, 1900.

At the Society for Innere Medizin Hr. A. Eulenburg showed a case of

GUNSHOT INJURY IN THE HEAD.

The patient, a man æt. 36, had for thirteen years carried a revolver bullet in the right middle fossa of the base of the skull. The speaker remarked that it was one of the two cases in which the bullet was discovered soon after the introduction of the X-rays. The man attempted suicide in 1886, the muzzle of the revolver being placed to the lower posterior part of the temporal bone and pointed obliquely. The scar still remained. On being admitted into hospital immediately after receipt of the injury, there was free hæmorrhage, protrusion of the right eyeball, and some cerebral symptoms. The symptoms subsided under treatment, and the medical attendants finally concluded that no bullet remained in the skull. In 1890, however, severe attacks came on, violent headache, general restlessness, shivering, excitability, and violent outbreaks of scorn and anger, without any corresponding excitation, so that the man had the behaviour of a wild beast. Then

came on a period of quietness, followed again by violent outbursts, and the man was at last sent into an asylum as a dangerous subject. There he remained five years. The patient himself had developed the idea that the bullet was still in the brain, wrongly so, as the medical attendants believed. In 1896 he came under the speaker's care, who ascertained by means of the X-rays that the bullet was indeed there and in the situation named. He had dissuaded the patient from having attempts made to remove it, as there were no longer any symptoms of cerebral disturbance. Since, then, however, the violent symptoms had returned, and he could now recommend operation for removal of the object. He would report later on the results of the operation.

Hr. Blumenthal gave a short note on

SIDONAL: A NEW REMEDY.

According to the investigations of Weiss, chinc acid had the property of limiting the formation of uric acid in the system. Jaffé and Darmstaedter had made a preparation by combining chinc acid and piperazine, and had forwarded a sample to the Klinik in order to have its actions ascertained. The testing of it had shown that the preparation really had a great effect in checking the formation of uric acid. If five to eight grammes of sidonal were given daily the excretion of uric acid was diminished from 40 to 50 per cent., the quantity of hippuric acid being increased. As there was no increase in the after periods, it was evident that the action was not simply to retain the uric acid in the system. As hippuric acid was very soluble in water it had no injurious influence. From the investigation it appeared likely that sidonal would be a useful remedy in gout.

Hr. v. Leyden believed it would be of importance in the uric acid diathesis. A remedy for gout was still a desideratum, especially one based on a scientific foundation. The theory of gout was by no means quite clear, but in any case uric acid played a leading part in it. He had used sidonal in private as well as hospital practice, and he could say that it was well borne, or had no disturbing influence, and was taken readily as the attack was favourably influenced by it. It was not yet known whether an attack could be cut short by it.

Hr. Jacques Meyer had employed sidonal in five cases of typical gout, and in five cases of undoubted renal concretions. The daily dose was five grammes, one half in the morning and the other in the evening. The average duration of the trial was seven days. No unpleasant effects were observed. As regarded therapeutical action, the attack ran a quicker course than usual—the pain and swelling passed off comparatively quickly, and power of movement returned more quickly than usual. In the cases of renal concretion the subjective symptoms were either diminished very considerably or they disappeared altogether.

Hr. Goldscheider had used it with good results in two cases of true gout.

Hr. Edmund Meyer reported on its use in two cases one of them being that of Geh. Rat. B. Fraenkel, who used it on himself with a favourable result. In the other case also the attack passed off more quickly than usual.

At the Medical Society of the 21st ult., Hr. Virchow showed a man, æt. 40, with

SUBCUTANEOUS FISSURE OF THE STERNUM, in which the cardiac movements could be felt with the

greatest plainness. The place of the sternum was supplied by fibrous tissue.

Hr. Senator remarked that the case exhibited some physical phenomena. On inspiration a deep drawing in of the tissue over the absent sternum took place, and on expiration a corresponding bulging or prominence. The heart glided upwards when the man lay down. On compression of the arch of the aorta whereby filling of the peripheral arteries took place, the recoil elevation was felt more strongly in the radial artery. The Röntgen image showed that it was the aorta that was compressed.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, March 21th, 1900.

ENTEROPTOSIS.

THE discussion of enteroptosis which was introduced to the "Gesellschaft der Aerzte" by Herzfeld has at last come to an end. Herzfeld, in his introduction, reviewed the theories of Glénard and others. The principal symptoms are disorder of the stomach and bowels, with loss of appetite, yet having a feeling of hunger; after every meal pain, knocking, and pressure; constipation and diarrhoea ultimately with gaseous swelling; difficulty of breathing, palpitation, vertigo, headache, and emaciation. These symptoms are often represented as hysteria, but enteroptosis must be distinguished from this vague disease according to Herzfeld's teaching as a separate disorder, whose proximate cause depends on some intra-abdominal pressure. Glénard has suggested a relaxation of the flexura coli hepatica and subsequent lowering of the colon ascendens, transversus, and internal organs as kidneys, stomach, spleen, &c. Herzfeld is inclined to believe the symptoms are due to a downward pressure of liver which paralyses the bowel, producing the nervous and gaseous condition.

Tandler reminded Herzfeld that the liver did not "swim" on the intestine as he would have us assume, but was connected to the diaphragm by ligaments composed of folds of the peritoneum, or duplicates that could be demonstrated on the dead body. Again, Herzfeld assumes that the relaxation of the abdominal walls allows the bowel to descend, and by this separation produces a dragging on the omentum; but this hypothesis is also negated by the physiological fact that blood rushes into any space with relaxed vessels till the pressure is restored, which would prevent such a phenomenon as dragging of the omentum or suspension of the peristaltic action from distention by having no support for the outer walls.

No space is allowed to stand vacant, as the hæmatic pressure soon restores the equilibrium, and therefore negatives the assumption that displacement or dragging would alter the pressure on any part of the external bowel after the morbid position was assumed.

Herzfeld presumes that enteroptosis is more frequent than is generally admitted, and appeals to the testimony of Stiller in his past cases where the bowel was found more frequently displaced than normal. This is in accord with Virchow's experience, who affirmed that the entire contents of the abdomen may have a statutory position, but the exceptions were more frequent than

the rule. If this be so, how comes it that only 36 cases are yet to be found in the whole of our literature?

Again it often occurs that the axial attachment of the embryonal kidney with the mesentery is often abnormal, and no enteroptosis is ever observed. The same may be shown of the spleen. On the other hand it can be equally shown that a long mesentery giving no support whatever from its superfluous extension is found to have no bad effect, nor can it be said to be advantageous.

Braune has also advanced a theory of intra abdominal pressure to explain the cause of enteroptosis by accusing the femoral vein with this variation in the abdominal cavity, but from personal observation and experiment Tandler found such a hypothesis to be of a negative character, unless pressure was applied to the abdomen. The bowels hang without any perceptible weight as the head of the femur within the acetabulum, which is quite against the compression theory. As to Glénard's hypothesis of the sinking of the flexura colidextra and dragging down of the kidneys, every pathologist who has carefully examined the dead body will admit the fallacy. On the contrary Tandler has met with abnormally long flexure with the horizontal part of the duodenum wide, bulging and loose. It is strange that all the writers on enteroptosis never mention the conditions that should occur when it is considered that the cardiac end of the stomach is attached to the diaphragm, although most of them affirm that the stomach sinks, which must necessarily extend the length of that organ.

Stiller, on the other hand, maintains that the pathognomonic symptom and proximate cause of enteroptosis is the free movement of the tenth rib, which is due to a skeletal malformation! This is too ludicrous to dwell on. Anthropologists have demonstrated that no trace of neurasthenia or enteroptosis exist in such cases.

Sternberg thought that all were agreed that enteroptosis was a nervous intra-abdominal disease, with very complex symptoms in assimilation and absorption. Notwithstanding the testimony of our worthy pathologists, one symptom when standing and lying is very prominent in this disease. The elastic contraction of the abdomen is lost; when the patient stands it is pendant, when he lies down it again falls back, which is best demonstrated by placing the patient on his elbows. Irrigation has no effect in any position. Hepatoptosis is easily recognised by the low position of the external part of the lower margin of the liver. For the movement of the kidneys he thought that was no reliable symptom of enteroptosis.

Knöpfelmacher said that Herzfeld laid great stress on one symptom as pathognomonic of enteroptosis, viz., abnormal flaccidity of the abdominal and pelvic muscles. He quoted from two of his own cases where stomach and tension of abdomen were normal, but kidneys, spleen, and liver were movable. He considered the disease depended on a large number of factors.

Wolfgang Pauli thought the frequency of this disease was surely over-estimated; a lowering of the smaller curvature of the stomach, and an abnormal movement of the parenchymatous organs were very frequently met with when no enteroptosis was present. He recounted a case with ascites, pendant liver and fluttering of vena porta with no enteroptosis.

Kumpf said splanclonoptosis was a very rare affection.

In 200 cases investigated by himself he found the transverse colon displaced in 40 per cent.; nephroptosis 40 per cent. in females, and 20 in males. The etiology cannot depend on intra-abdominal pressure, but rather on loss of external support, such as the abdominal walls or skeletal frame.

Continental Notes.

[FROM OUR SPECIAL CORRESPONDENT.]

HYÈRES-LES-PALMIERS.

THE French Riviera has not had a good Winter Season; the South African War, or other causes, having kept at home many British and other usual *habités*. The weather, too, along the Mediterranean coast has not hitherto been inviting. There have been more cloudy and windy days than sunny ones. Now brighter weather comes, and with it many visitors of all nationalities; coming not only from the British Isles, but from Egypt, Southern Italy, Rome, and especially America.

To those who come thus late to the "Azure Coast," Hyères offers advantages. For the rest-seeker, the delicate, and the convalescent, and to all who for any reason desire a quiet health-giving spring home, it is admirably adapted. It is the most southern and the sunniest spot on the Riviera; yet from its peculiar position between the hills and the sea, visitors can pleasantly come to Hyères earlier and remain later than at any other resort on the whole coast; Grasse alone competing with Hyères in this respect.

The Castle heights completely shelter the town from northerly gales, and other chains of hills running east and west protect it from the force of mistral winds, which annoy so greatly Bordighera and other easterly Riviera stations. The vegetation in and around Hyères testifies unmistakably to the genial character of its climate; the luxuriant palms lining the avenues, the abundant orange, lemon, and pomegranate groves, and the continuous really over-profusion of flowers, evidencing beyond controversy to the happy climatic conditions of Hyères; buds and fruits appearing here side by side all the year round. These conditions have been utilised by the inhabitants of the neighbourhood; the whole country side from Hyères towards Toulon being a territory of floral and market gardens; supplying the earliest flowers and vegetables to London and Paris.

The less variations of temperature, the pure, dry, and tonic atmosphere, make Hyères a very desirable winter and spring home for those predisposed to asthmas, catarrhs, and all respiratory troubles; gout, rheumatism, Bright's disease; and for the debilitated, overworked, convalescent, and delicate. For such Dr. Clarke pronounced the climate of Hyères "to be the mildest and *safest*" on the Littoral. Hyères also enjoys a special advantage, for those who, while they cannot well stand the stimulating effects of a residence immediately upon the seaside, yet wish to profit by the purity of air which saline-atmospheric movements produce. The town is three miles away from the coast, but in its atmosphere is found the beneficial influences of proximity to salt-water.

Life is cheaper at Hyères than at any other of the leading Riviera resorts. And as it is the oldest of the English winter-homes on the Riviera, English com-

forts abound and English tastes are catered for; apartments, pensions, and hotels abound of all grades and prices. Among the preferable hotels may be named the well-known *Hotel des Hesperides* and the *Grand Hotel des Palmiers*.

Hyères is likewise a convenient centre for excursions; on foot, or by bicycle, carriage, and rail. In its immediate vicinity are various antiquarian objects of interest and many attractive walks. From the ruins of the Castle (overlooking the town) the landscapes are grand. About five miles away are the foundations and other remains of the Gallo-Roman city and harbour Pomponiana. We first hear of this part of the coast from Strabo; who tells us that the Roman General Sextius (B.C. 125) defeated the confederated tribes of the Salyses whom the citizens of Marseilles had not been able to overcome. Sextius compelled the Salyses to relinquish their possession of the harbours and a strip of land varying from 8 to 12 *stadia* along the coast; and that he donated the territory thus obtained to his allies the Massiliots.

Within an easy drive or cycle run west from Hyères is the famous fortified town, Toulon, a place full of modern interest in its forts, fleets, and arsenals; the greatest, naval station of France on the Mediterranean. Tuesdays and Saturdays are the favourite days for a visit to Toulon, as on these afternoons the fine military bands play in the public gardens. In these gardens is an antique porch, brought hither from an old Phœcean city on a hill-top of Cape Sicier. Another relic, on the Quai du Port of Toulon, is the hulk of the vessel which brought Napoleon's body from St. Helena in 1840. The Marine Museum contains various nautical models. The military Dockyard and the Arsenal are the objects of most interest to Toulon visitors, and at Hyères the ladies will also tell you that Toulon is excellent for an afternoon's shopping!

In marked contrast to the nineteenth century life and animation of Toulon is the old-time town of St. Tropez with its narrow streets, quaint wharves, and leisurely population, reminding one much of a mediæval Dutch small fishing port. Those at Hyères in May should not fail to visit St. Tropez at the local *Fêtes des Bravades* (held May 16th to 25th), in honour of the victory gained over the Spariards in 1637 by the sailors of St. Tropez. The fish market is also worthy notice, and the sea views are lovely from the Citadel beyond the town. The wood carvings in the Church are curious, especially that of the boat conveying the headless body of the saint. The legend runs that St. Tropez was one of St. Paul's guards at Rome, who, becoming a Christian, was beheaded; the head and body were cast into a boat which floated ashore here.

St. Tropez is reached by a narrow-gauge railway which runs along the picturesque coast.

Among the Maures mountains near Hyères are vestiges of Saracenic strongholds and of several chateaux of the celebrated Grimaldi family. The narrow-gauge railroad also leads to the classical Frejus, "the Golden Gate of Gaul," with its fine ruins of amphitheatre and aqueduct; and to the very modern French seaside resort of St. Raphael, so dear to Alphonse Karr, Sainte-Beuve, and Charles Gounod.

Farther away is Aix-en-Provence, with its memories of Marius (the Field-Marshal Roberts of the antique world) who here 2,000 years ago again taught the Roman

legions how to conquer and how to hurl back the barbarian hosts of Cymbri, Teutones, and Ambrone, who for nine years of panic had threatened to overwhelm all the world then possessed of civilisation. Near Aix at Glanum, Marius's Camp, still stands his triumphal arch and three-storied monuments. And also near Aix at Entremont (scarcely known even to French archæologists) are much more ancient remains; the bas-reliefs taken thence to the museum at Aix being the sole sculptured specimens now extant of the Ligurians, who, prior to Roman days, inhabited these Mediterranean shores. For excursions here the softly lengthening days of April and May are of all the year the choicest. And, for those who prefer the beauties of nature, in these months the country immediately adjacent to Hyères is at its prime. Every wood, glade, and hillside is brilliant with superb verdure, and abundance of wild flowers, and the birds are singing joyously.

The Operating Theatres.

MIDDLESEX HOSPITAL.

TWO EXCISIONS OF THE TONGUE.—MR. ANDREW CLARK operated on a middle-aged man with a small epithelioma occupying a patch about the size of a sixpence on the right edge of the tongue about the centre. It was of recent duration, and did not appear to implicate the glands. Scissors were employed to remove the right half of the organ, and no difficulty was experienced in picking up the small vessels, the lingual artery having been secured by pressure forceps when met with during the operation. Before commencing the cutting a silk ligature had been passed through both sides of the tongue to support the side of the organ not removed, and to draw the part removed forwards. The raw surface was painted with Whitehead's varnish, and the patient returned to bed.

The second case was somewhat similar, but the growth was at the extreme back of the tongue, almost reaching the anterior pillar of the fauces. The patient was a middle-aged man, and there was no implication of the glands. In this case laryngotomy was first performed, and the anæsthetic administered through the tube. Ligatures were put through the tongue as in the first case, and the pharynx was plugged with a suitable sponge; scissors were employed, and after the organ had been split down the centre the anterior pillar of the fauces was divided; this enabled the tongue to be drawn forwards sufficiently to introduce the scissors clear of the disease; the organ was then removed, and the bleeding stopped in the same way as in the first case. The raw surface was painted with Whitehead's varnish and the patient returned to bed with the laryngotomy tube still *in situ*.

Mr. Clark said that in all cases where it was practicable he preferred this method of operating to any other. The clean cut made by the scissors rapidly healed, and the patient was usually able to be about again in less than a fortnight. In the second case, owing to the position of the growth, it would have been difficult, and perhaps impossible, he said, to have arrested the bleeding until a serious amount of blood had been lost, had the operator had been hampered in so small a space as the mouth with the chloroform inhaler hence laryngotomy was

first performed as preferable to laying open the cheek. There is, he pointed out, usually no difficulty in seizing the lingual artery before division, but if that is not practicable, provided there is plenty of room and a good light, it is easily picked up the moment it is divided. The laryngotomy wound rarely gives trouble, it heals up as quickly as the tongue, but it is wise, he thought, to leave in the tube for a few hours after the operation in case there should be any further hæmorrhage.

TOTTENHAM HOSPITAL.

VAGINAL MYOMECTOMY.—DR. ARTHUR GILES operated on a woman, æt. 44, who had been admitted with the following history:—She had suffered from menorrhagia for two years. This had lately increased until for the few last weeks she had almost constant hæmorrhage. Six weeks before admission she began to suffer from severe abdominal pains, which she compared to labour pains. During this time she had also frequency of micturition. On several occasions just before admission she suffered from retention of urine. She complained of very offensive vaginal discharge and of considerable loss of flesh. She was the mother of six children, the youngest of which was nine years old. On examination a mass was found in the abdomen, rising half-way to the umbilicus, its upper border was nodular. By the vagina a mass was felt about the size of a foetal head reaching down to within an inch of the vaginal orifice; it appeared to fill up the pelvic cavity. The surface was rather rough, and the mass was diagnosed as a sloughing myoma partly extruded from the cervix uteri; the fingers could not however be passed beyond the mass so as to ascertain the relations of its pedicle to the cervix. Examination with a speculum showed that the tumour was in parts necrotic. Vaginal myomectomy was resolved upon. The patient being anæsthetised, an attempt was first made to rotate the mass in the vagina, but this was not found practicable; in view of the impossibility of reaching the pedicle directly, the operator proceeded to bisect the myoma in the median plane with scissors, after which the right half was freed by transverse cuts near its attachments; it was then found possible by introducing the hand into the vagina to ascertain the relations of the growth; it was felt to arise from the posterior wall of the cervix by a pedicle one inch in diameter. The pedicle was cut through with scissors and the left half of the tumour removed. The cervix then presented a remarkable appearance, for its margin had been spread out by the growth and had become greatly thickened, they somewhat resembled a red rubber ringed pessary of a diameter of 2½ inches. The bimanual examination at this stage showed that the body of the uterus was not involved in the growth, but had remained perched on the top of it, giving rise to the nodular feeling experienced on abdominal examination. The operation was attended with but little hæmorrhage owing to the necrotic character of the myoma. The uterine cavity was douched with 1 in 2000 perchloride solution at 115 degs., and packed with iodoform gauze. Dr. Giles pointed out that this was an interesting and rather uncommon type of myoma, namely the large intracervical. As was the case with all large cervical or intracervical myomata, the shape was ovoid, corresponding fairly well with the pelvic cavity to which it had become moulded; he further remarked that the most

characteristic pressure symptoms were found associated with this group of cases, interference with the functions of the bladder and rectum being the most conspicuous, this was of course due to the fact that the enlarging tumour could not rise above the pelvis brim as was the case with myomata springing from the body of the uterus. Intracervical myomata, he said, showed a special tendency to sloughing, and they became partly extruded because the thickened cervical lips tended to compress the pedicle and interfere with the nutrition of the tumour; the process might be regarded as a spontaneous attempt at cure, but unless interference were resorted to, the patient was apt to suffer considerably both from pressure and from sepsis before the desired result came about. In cases of myoma of this size occupying the vagina, the only way to deal with them was to remove them in two or more pieces.

It is satisfactory to state that the patient is progressing favourably.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, MARCH 28, 1900.

THE CAUSE OF SUMMER DIARRHŒA.

THE Milroy lectures of the Royal College of Physicians of London have this year been devoted to the important subject of summer diarrhœa. The terrible infantile mortality due to that malady has long been the despair of sanitarians, but there seems to be a reasonable amount of certainty that sooner or later it will cease to be the scourge of our urban populations. In the year 1898 the number of deaths in England and Wales from epidemic diarrhœa alone reached the great total of 30,077, and 31,069 in the following year; in 1898 the death-rate from the seven principal zymotic diseases was 12·6 per cent. of the total mortality, and of that amount no less than 5·4 per cent. was due to diarrhœa, while the corresponding figures for 1899 were 12 and 5·3. These facts illustrate the great extent of the problem to be solved, namely, how to prevent this preventable malady.

The main features of the disease are highly characteristic and peculiar. Among them may be named its incidence upon the infantile urban populations during hot and dry summers, and its close relation to air and earth temperature curves. The Milroy lecturer, Dr. F. J. Waldo, regards the malady as due not to one but to various micro-organisms, which form an infection of a manifold and often of a mixed nature. He showed by means of an exhaustive analysis of the returns of the different counties in England and Wales that the causes of excessive diarrhœa mortality are mainly local, not climatic and that, although high temperature and low rainfall may be necessary factors in producing a serious outbreak, presumably they produce it only in the presence of certain other conditions. The exclusion of climatic influences as the main essential antecedents is supported by the observation that in a county temperature and rainfall may be practically the same over neighbouring areas, of which some may suffer heavily, and others lightly from epidemic diarrhœa. What, then, are the essential local conditions that excite diarrhœa? First and foremost, there can be no reasonable doubt as to the bacterial nature of the affection, whatever obscurity may surround the agency of its distribution. The late Dr. Ballard, whose classical report upon the subject was issued by the Local Government Board in 1889, attributed the disease to a hypothetical microbe, with a habitat in the upper layers of the soil. One of his most famous observations was that the summer rise of diarrhœal mortality did not commence "until the temperature recorded by the 4-foot earth thermometer has attained somewhere about 56 degs. Fahrenheit, no matter what may have been the temperature previously attained by the atmosphere or recorded by the 1-foot earth thermometer." It is not surprising that Ballard wanted to attach great importance to the part played by deep earth temperatures, especially when he also found that the maximum diarrhœal mortality of the year was usually observed in the week in which the temperature recorded by the 4-foot thermometer attained its mean weekly maximum. The task that lay before the Milroy lecturer was to bring a large collection of facts such as the foregoing within the four walls of a common explanation. This he has done by advancing a theory as to the causation of epidemic diarrhœa that is both simple and striking, and that appears to tally with all that is known of the malady. Briefly he regards the infective agency as a surface and air borne pollution in the shape of town street dust, and the specific polluting agency as horse-dung. Our knowledge of the bacteriology of the human intestine and of the horse, both in health and in disease, is still in a most imperfect condition. Dr. Waldo, however, showed that a number of organisms are common to the intestine of the human and the equine animal, and that some at least of those bacteria are pathogenic. His proportion admittedly falls short of proof in our present state of knowledge, but it explains clearly enough the why and wherefore of many of the vagaries and peculiarities of diarrhœa.

The one great essential distinction between town dust and country dust lies in the enormously greater proportion of horse-dung met with in towns. As a surface and floating contamination it would be washed out of the air and away from outdoor surfaces by rain. Dust has marvellous powers of penetration and diffusion, as shown, for instance, by the way it reaches the interior of a watch, and it has free access to larders and other places where food is stored. This happens in the case of milk, which is kept, as a rule, in open vessels in the shop of the retailer, where it can be freely polluted by street dust. In this way the incidence of the disease upon infants, especially the handfed, who suffer disproportionately from the ravages of diarrhœa, is accounted for. Pollution by street dust of fruit exposed for sale explains why a child may eat plums with impunity in the country but not in the town. Dr. Waldo accepts observation as to the deep earth temperature as quite reconcilable with his own view, inasmuch as the vitality of the dust micro-organisms may be closely connected with the mean temperature of the surface on which they lie. The theory affords a key to the universal town distribution of a specific epidemic malady, and whether true or not it constitutes one of the most brilliant contributions yet made to the study of this enormously fatal disease. In the long run it cannot fail to emphasise the necessity for close attention to the sanitary state of the street environments of our towns, to the structure of our larders, and to the desirability of substituting motor for horse traction. One more scathing scientific indictment has been drawn up against dust, and upon æsthetic grounds alone the average citizen will object to have his house invaded by such filthy material as dried and pulverised horse-dung. If diarrhœa be established as a dust disease, then the difficulties that stand in the way of its future prevention will be vastly lessened.

THE FUTURE OF ASYLUM SERVICE.

[SECOND ARTICLE.]

SINCE writing the previous article the evidence that this question has come to the front is still more manifest by the appointment by the Glasgow District Lunacy Board of a committee to inquire into the matter. The committee has reported that the matter will come up for discussion immediately. From the report of the committee it is apparent that in their view the whole question is summed up under three things—pay, hours of duty, and leave. We are not quite clear from the rather confused newspaper report which has appeared as to what the committee means regarding either of these three points, but they have made this fact sufficiently clear, that they are aiming at improving the conditions of service. While we are pleased to notice an active movement in the direction of improving asylum service, we must admit that in no case has there been presented evidence of that wide grasp of the subject which is essential to the real solution of this question. It is necessary first of all to bear in mind that the conditions, favourable and un-

favourable in any two asylums, are not exactly similar, and that while general principles may be laid down there are individual and idiosyncratic questions of particular asylums, which require to be dealt with on their own special merits. There is the question of the geographical position of the asylum, its isolation or otherwise, railway and travelling facilities in connection with it, or in other words, means of getting relief from the irksome, and, in some respects, the monotonous routine of asylum life. There is, further, the question of the size of the asylum, the homeliness of the arrangements *versus* stricter discipline which is necessary in large institutions, the question of whether a private asylum is more attractive than a pauper asylum, the question of accommodation provided for nurses, the degree in which they are able to isolate themselves when off duty, and the social advantages provided for them. There is also the question of the social position of the attendants and nurses engaged, whether ward maids are employed to do the rougher work, and how far attention is devoted to raising the service, socially and intellectually. We have also to take into account pay and allowances, but by some asylum superintendents the question of pay is not considered an important one, while others, from a different experience or keener observation, recognise it as the crucial question of the whole matter. Now, it is a fact that cannot be disputed, that the average man and woman, no matter how foolish they may be in many respects, know that twenty shillings represent a sovereign, and that two sovereigns are better than one. It is also a matter not to be disputed that asylums have their drawbacks and that no more patent counter advantage can be demonstrated than a large pay, and it stands to reason that if we cannot see our way to give attendants an eight hours' day we must make it up to them in some other way. Therefore, it is becoming more and more a general idea that the pay of our asylum attendants must be raised. The pay is not merely a monthly question of pounds, shillings, and pence. It is a question of special and extra bonuses; it is a question of free houses for married men, of coals, light, allowance in case of sickness, medical attendance and medicines, including attendance at confinements; it is a question of uniform and other things. There is no doubt that the attitude in England of several of the committees of visitors of asylums towards pensions has done much to damage the welfare of asylum service. It is one of the undoubted advantages of the prison service, and this is proved by the low percentage of changes in that service, that a pension is assured for good and faithful service. In England this is optional, not compulsory, and matters have not advanced recently, and the position of antagonism taken up, the outcome of sheer prejudice and ignorance on the part of several prominent men, has done much to damage asylum service in England and to injure the best interests of the insane. We are speaking with full knowledge of the subject, and are not specially plead-

ing for asylum officials. We take this wider view that the best interests of the insane are secured by securing the well-being and permanency of asylum service. We take it that those who reason on a absurd radical lines that the pay is good enough and ought to provide for a rainy day, have not reckoned up the meaning of two important facts, first, that the frequent changes in the service for better pay and better conditions elsewhere are proof that the pay is not good enough, and second, that the strain of this kind of life, just as the strain of hospital nursing, only more so, breaks down the nervous system, brings on bad health, and reduces the average duration of life, and especially in women, to a degree that will rarely be found in any occupation outside of asylum service. It has also to be remembered that pensions in the police and other public services are recognised legally without option, and no man who honestly compares the two conditions of service will deny that the asylum service has a higher claim. The fact of the matter is that many of those who profess to speak with authority, even though they may be members of Committees of Visitors, have only seen the outside of asylum service, and know absolutely nothing of its real inner life with all its trials and difficulties.

Notes on Current Topics.

The Goulstonian Lectures.

THE subject chosen by Dr. Horton-Smith for the Goulstonian Lectures is one of great interest and importance. There is no doubt but that the line of research which Pasteur developed has proved of immense practical value to medicine and surgery, and it would be difficult to show any stronger evidence of the use of the microscope in the study and treatment of disease than by the work done by Pasteur and his followers. That difficulty which Harvey had in proving that the blood passed from arteries to veins was of course removed when the capillary system was exhibited. Now that the existence of bacilli is proved, and their peculiar properties can be studied in the laboratory as well as in the living body, important questions of prevention of disease are interesting the profession as much as those of treatment; which latter alone seemed to attract such men as Sydenham, Radcliffe, and their contemporaries. The curious character of symptoms in such a fever as typhoid are easily understood when their relation to the bacilli is explained. The human body resembles to some extent a case in which the culture of bacilli is promoted; and the singular manner in which various organs exhibit the effects upon them of bacillary invasion proves of the greatest interest to the clinical student. Dr. Horton-Smith's work has been carried on in the proper spirit, which we think ought to control the researches of microscopical pathology, namely, the practical use to which they can be turned for the benefit of mankind. Those who seem to despise science when applied practically

are, in our opinion, not deserving of much respect, and we are glad to see men like Pasteur and Lord Kelvin taking pleasure and finding profit in the honest and honourable utilisation of their scientific work. It is well that clinical observation should control the work of the laboratory, and that the two should co-operate. It would not be safe to trust too much to the microscope, for the imagination is liable to mislead when very high powers are being used. We are sorry to find that the lecture room of the College of Physicians is generally dreary and deserted when lectures are delivered which ought to attract decent audiences. Certainly Dr. Horton-Smith deserved greater attention in this respect than he received.

Suppression of Flash Lights.

THE London County Council have taken the initiative in regulating those objectionable advertising devices known as "flash lights," thus setting an example which may advantageously be followed by the municipalities of other large towns. We have repeatedly called attention to the discomfort and danger to which these sudden and impressive variations in illumination give rise, and it is satisfactory to find that this view has been emphatically endorsed by the County Council. The regulation which prohibits these fitful glares is a logical sequence to the law which put a term to the disfigurement of the super-terrestrial metropolis by "sky signs," and we are probably within measurable distance of the time when the authorities will claim and exercise the right to say something on the æsthetic aspects of pictorial advertisements. It is outrageous that streets should be left at the mercy of a horde of soulless contractors who vie with each other in the endeavour to afflict the eyes of the inhabitants.

Short-sighted Radicalism.

THE Metropolitan Radical Association have approached the Prince of Wales in his capacity of President of the Hospitals Fund with the request that he would receive a deputation on the subject of medical schools and laboratories in London hospitals in relation to the Prince's Hospital Fund. The principal argument seems to be that as hospitals with medical schools devote a certain fraction of the funds at their disposal to the maintenance of medical schools and laboratories, therefore the money subscribed by the public goes in part to the maintenance of institutions where vivisection is practised. The offer in respect of a delegation was refused, and a memorial was forwarded in which the main points were set forth. It is difficult to see what good result can possibly follow this ridiculous manifestation. To adopt the views of the memorialists would entail the withholding of subventions from all the large general hospitals, to the detriment of the suffering poor and without materially interfering with physiological research, which, after all, constitutes a very infinitesimal fraction of the work done in laboratories. In regard to the medical schools nothing could be juster than that the managers of hospitals should assist in

their maintenance seeing the enormous amount of unpaid work which students, dressers, and medical residents do in the wards. These short-sighted radicals lose sight of the fact that all medical services are rendered gratuitously, and that the work of the hospital could not be carried on at its present standard of excellence were it not for this gratuitous assistance. It is no good arguing with such people, but what might be done is to instruct them.

Military Dentistry.

THE rejection of from 10 to 25 per cent. of recruits for the Services on account of bad teeth is a serious matter, especially in view of the fact that in ordinary times considerable difficulty is experienced in keeping up the supply of men. It is surely rather short-sighted to place bad teeth on the same disqualifying footing as heart disease, deficient chest measurement, or other constitutional defect or infirmity. Bad teeth, after all, constitute only an accidental and essentially remediable disqualification though the men thus denied entrance into the Services for this reason may not be in a position to pay a dentist to put matters right. The question suggests itself whether it would not be worth while for the Government to subvention a dental hospital in order to acquire the right to send men there to have their teeth seen to, nay, it might even be good policy to enrol a corps of military dentists as a sort of adjunct to the medical corps. The soldier's weak points, we are told, are his stomach and his feet, and the condition of his stomach is intimately associated with that of his teeth. His teeth require looking to as systematically as his boots, for a soldier who has an aching molar cannot be trusted to obey orders with the cheerfulness and promptness which his officers expect. Bad teeth induce chronic dyspepsia and chronic dyspepsia drives men to drink, so that in the interests of the Services as well as of the individual warrior provision ought to be made for dental assistance.

Teetotal Doctors.

THE members of the medical profession have probably done more than any other class of the community to advance the cause of temperance. By virtue of their occupation the evil results of alcoholism upon the human species are constantly before them in the consulting room, at the bedside, in the asylum, and in the post-mortem room. The graphic pen of more than one physician has recorded powerful sketches of the misery, disease, ruin, and death caused by the abuse of strong drink. Yet it may be doubted if the number of medical men who are total abstainers has notably increased of recent years. The fact appears to be that the majority of the profession are moderate drinkers. At the same time they certainly would do all in their power to discourage anything other than the strictest moderation in grown up persons, and would for the most part decline to sanction the administration of alcohol in any shape or form to the young. The times have changed so that excessive drinking

has gone out of fashion among the upper and middle and to a great extent among the labouring classes, and the medical profession nowadays floats with the stream that it has had no small share in creating. There is one practical point that the practitioner will do well to bear in mind every day of his working life, namely, not to order alcohol to patients except as a medicine. If a patient determines to be a moderate drinker let him act on his own responsibility. For some weak vessels the only safety lies in entire abstinence, and there is no doubt that many a chronic alcoholic dates his malady from "doctor's orders."

Slaughter House Inspection.

THAT a great amount of disease in the United Kingdom is due to the sale of the flesh of diseased animals is a proposition that cannot admit of serious question. In spite of the recognition of this fundamental principle in prevention, however, the fact remains that in many towns there is absolutely no attempt whatever on the part of the authorities to control the meat traffic by efficient skilled inspection of slaughter houses and of shops and markets where meat is sold. The number of offences brought to light in the Metropolitan markets shows to what an extent this nefarious traffic is carried on. What must it be in the districts where official control is a dead letter? The inspection of meat involves highly technical and advanced knowledge, and at times demands the aid of the microscope and of bacteriology. It commonly happens, however, that where the flesh presents obscure or doubtful traces of disease yet the lungs and viscera may be in an advanced stage of disorganisation. The necessity for inspection of the carcasses in slaughter-houses, therefore, will be apparent. In a recent case at Bath the Medical Officer seized the carcass of a cow that was ill for ten days after calving, and was killed by a butcher who had bought the animal for £2. The meat was dressed and skewered for market and would not have attracted attention apart from the lungs and larger blood vessels. For the offence thus disclosed the butcher was sent to prison for a month without option of a fine. Curiously enough, the greatest opponents to the reform of slaughter-houses are the butchers themselves. Before long it seems likely that the present abuses will be swept away root and branch by the strong hand of educated public opinion.

How the Country Doctor can Aid Medicine.

THE day has long since gone past when the term "country doctor" carried with it more or less of reproach. To-day it may be said of members of the class in question that they are often men of good qualifications and high professional attainments. The long distances to be covered afford them abundant opportunity for reflection, and many a thinking mind has been moulded under such circumstances of special environment. The necessities of the case bring the rural practitioner more into contact with the art than the mere abstract theory of his work, whereby he is enabled to a great extent to

winnow the wheat of experience from the chaff of the schools. There can be no doubt whatever that the minds of our country brethren are richly stored with facts of the highest value as regards the action of remedies and of other practical branches of the healing art. Unfortunately the benefits of these special experiences are as a general rule lost to medicine, for the observations are rarely put on record, even in the shape of a passing letter to a medical journal. The chances of communication by word of mouth are few and far between, but no one who has ever driven round with a country surgeon for two or three days is likely to forget the sense of practical reality that stamps his professional views. If any scheme could be devised for collecting and analysing some portion of the vast amount of exact medical observation now buried in rural solitudes it would confer a solid benefit upon medicine as an exact science. Perhaps some of our country readers will commence by sending in notes of rare and interesting cases they have met with in practice.

The Dublin Sanitary Commission.

THE Commissioners appointed by the Lord Lieutenant to investigate the causes of the excessive insalubrity of Dublin have concluded their sittings and are preparing their report. If that report is to be a reflex of the evidence heard by the Commission we fear it will be disappointing, and that no effective remedial measures will result. The greatest part of the time of the Commission has been occupied with testimony as to the universal prevalence, within the city, of uncontrolled filth and reprehensible negligence of sanitation, of the bad effect of dairy-yards and slaughter-houses under the windows of the dwellings of the poor, of the utter abomination of the tenement houses and the bestial condition of a considerable number of streets which the Corporation has left derelict. All this has been known to every intelligent citizen for years, and we cannot discover that any interesting suggestion has been added thereto save that of one witness, who thought that it would help to re-establish salubrity if ragged boys were prohibited from screeching "stop-press edition" in the streets, or driving with their friends to the cemeteries on outside cars. Dublin has, indeed, learned from Superintendent Medical Officers of Health brought from Manchester, Glasgow, and such centres what it might do if it had a million-and-a-half of money to expend on immediate sanitation, and a cleanly and law-abiding constituency to deal with, but most of their suggestions are *in nubibus*, and may pass. We are disappointed because we should have hoped to be instructed as to the changes in the law, and in the Corporate regulations which may be necessary to bring usurious tenement land, lords and squalid tenement occupants within the reach of the law—as to the amount which the City must expend, at the lowest estimate, on houses for the very poor, and as to many practical details which do not seem to have been touched by the evidence heard by the Commission. We are, perhaps, not justified in

assuming that the Commission will consider itself limited to the finding a verdict "according to the evidence," but, if it does, we anticipate that its report will go to keep company with the many blue volumes which encumber shelves but produce no other satisfactory result.

Psychological Pathology.

If we are ever to arrive at an understanding of the causes and cure of insanity it is evident that we must commence by approaching the subject from a scientific standpoint, for which reason we highly approve of the resolution adopted by the Dublin University Biological Association to the effect that, "In the opinion of the Association it is desirable to establish a central laboratory for the Irish Asylums, devoted to the study of pathology in relation" "to nervous and mental diseases." At present the pathology or remedy of madness is the *terra incognita* of the physician.

L'Homme à la Fourchette.

LAUSSEUR, the man whose name has been immortalised in connection with the fact that he was the patient from whose stomach Labbé, the great French surgeon, first performed gastrotomy for the removal of a fork, has just died, twenty-five years after the operation. *L'homme à la fourchette* created an immense sensation at the time, as it was the first occasion on which a foreign body had been removed from the stomach by a surgical procedure. Inasmuch as the operation really consisted in cutting down on an abscess in the region of the umbilicus, and the removal of the fork which was projecting into the wound, it was not, strictly speaking, a gastrotomy.

The Royal University of Ireland.

THE Under Secretary of State for War has placed Commissions in the Royal Artillery, the Infantry and the Army Service Corps at the disposal of the Vice-Chancellor of the University, who has requested the Senate to select names to be submitted to him for nomination. All gentlemen, members of the University, of at least second university standing, who are British subjects, between the ages of twenty and thirty, unmarried, are eligible. Applicants should send their applications, accompanied by copies of testimonials, &c., to the Secretaries, the Royal University of Ireland, on or before March 31st.

Exemption of Hospitals from Rates.

WE regret that the Government should appear disposed to accord a sympathetic ear to the advocates of the exemption of hospitals and similar institutions from the payment of rates; in fact, a committee is to be appointed to inquire into the matter. If it were a question of exempting these institutions from paying an imperial tax, the Government would probably prove less amenable to argument, but as the Treasury would not be called upon to remedy any deficiency in municipal funds caused thereby, the proposal meets with no official opposition.

The Medical Superintendent of Statistics for Ireland.

THE intention of the Government to appoint a medical expert to act with the new Registrar-General, Mr. Matheson, in the collation of medical statistics of the Irish Registration Office, was stated in Parliament last week in answer to a question by Mr. Arthur Moore. The salary is to be £350, rising £15 a year until £500 is reached. The announcement has brought out a crowd of competitors, and we expect to read in certain Dublin newspapers the asseverance that no one can possibly be depended on to register vital statistics unless he professes the same religion and politics as the newspaper in question.

Promiscuous Expectoration.

THE Paris Municipal Council has displayed on lampposts and elsewhere, warning, to all concerned that, spitting on the pavement is both offensive and dangerous to the public health. As a means of educating the street reader of such notices, this is a wise and necessary move, and, we doubt not, will produce good effect. It is, as a beginning, far more sensible than the method of coercion by the policeman and the spit mug advocated by some of our own sanitary enthusiasts.

Hunterian Society.

At the meeting to-night (Wednesday) of the Hunterian Society, the President, Dr. Dundas Grant, is to deliver an address on "Traps and Pitfalls in General and Special Practice." This will be followed by a paper by Mr. David Ross on "Some Points in the Therapeutics of Gout."

ONE of the funniest ideas in the way of supplying comforts for our soldiers in the field is that for which we are indebted to Mrs. Marion Lee, who solicits contributions to enable her to dispatch a supply of *Eau de Cologne* to South Africa. We are assured that this "olfactory food" will be highly appreciated by the wounded, but really it is open to question whether the average soldier would know what to do with it. Failing instruction in its virtues, he would probably drink it.

THE committee of the Liverpool School of Tropical Diseases have decided to admit qualified medical women to their classes on the same footing as men students, a concession which will commend itself to every one, in view of the rôle that women doctors may be called upon to play in malarial countries.

THE number of women possessing the certificate of the Obstetrical Society of London in midwifery is about 4,390. With regard to the Royal College of Physicians in Ireland only forty-nine women are thus certified, and it is stated that no certificates have been issued since July 1899.

DR. HORROCKS, on whose behalf a fund had been started for the purpose of defraying the expenses entailed by his defence in a recent divorce suit, writes to say that though he is very grateful for the many testimonies of sympathy he has received he prefers

that no subscription should be instituted for the purpose.

SINCE the 26th inst. the offices of the Metropolitan Asylum Board have been transferred to the new buildings on the Victoria Embankment, at the corner of Carmelite Street. In future the Ambulance Department will be open on Sundays, Good Friday, and Christmas Day from 9 a.m. to 8 p.m., as on week days.

A SADDLER of Sandgate (Surrey), who had ventured to state in public that Mr. How, L.R.C.P., M.R.C.S., was "no doctor," not having passed his examinations, finds himself called upon to pay £100 and costs by way of compensation, consequent upon a trial last week in the Queen's Bench Division.

ACCORDING to the *New York Sun*, Brooklyn has been afflicted of late with an epidemic of suppurative otitis involving the mastoid cells, following, and probably dependent upon, a mild epidemic of German measles.

FOR speaking disrespectfully of British Generals and British soldiers in the South African war, a student of McGill's College, Montreal, was recently ducked in the dissecting vat by his indignant fellows.

THE first meeting of the Standing Committee on Law to consider the Midwives Bill met on Friday last, with Mr. Lawrence Hardy in the chair.

THE annual meeting of the Medical Graduates' College and Polyclinic will be held at the College in Chenies Street to-day (Wednesday) at 6 p.m.

PERSONAL.

LORD LISTER has been appointed Serjeant-Surgeon in Ordinary to Her Majesty the Queen, *vice* the late Sir James Paget.

MR. FREDERICK TREVES has been appointed Surgeon-Extraordinary to the Queen.

PROF. OSLER is a candidate for the professorship of medicine in the University of Edinburgh.

DR. HUGH J. M. PLATFAIR has been appointed gynaecological surgeon to the Metropolitan Hospital.

H. CAMPBELL THOMSON, Esq., M.D., M.R.C.P., has been elected to the office of assistant physician at the Middlesex Hospital.

DR. ALFRED EDDOWES, M.R.C.P. Lond., has been appointed physician for diseases of the skin to St. George's and St. James's Dispensary, King Street, Regent Street, W.

SIR WM. GAIRDNER, in concluding the winter course of medicine at Glasgow University, on Friday last, bade his pupils farewell, he having decided to resign the chair of medicine.

MR. F. J. MARSHALL, who, for a quarter of a century filled the post of resident medical officer to St. George's Hospital, has been presented with a cheque for a hundred guineas and various articles of plate in commemoration of his tenure of office.

MEDICAL SOCIETY OF LONDON.

THE meeting on Monday evening last (March 26th) was devoted to the consideration of certain aspects of the pathology of gout.

Dr. LUFF read a paper on "The Gelatinous Form of Sodium Biurate and its Bearing on the Treatment of Gout," in which he discussed the circumstances under which the soluble sodium quadriurate underwent conversion into sodium biurate, first into the gelatinous and soluble form and then, if not eliminated, into the crystalline and almost insoluble variety, the precipitation and deposition whereof in various structures caused the gouty paroxysm. By increasing the alkalinity of the blood with sodium bicarbonate the conversion of the gelatinous biurate into the crystalline form was accelerated, whereas the addition of potassium bicarbonate had a retarding effect. Lithium salts retarded the process of conversion, but piperazine neither delayed the initial conversion nor materially slowed the conversion when once started. Lysidine delayed the onset of the change, but when once started had practically no effect. He admitted that the beneficial action of the salts could not be solely gauged by their solvent action on deposits of sodium biurate or their retarding action on the conversion of the gelatinous into the crystalline form. He insisted on the fact that the alkalinity of the blood from the presence of sodium bicarbonate determined more rapid and more complete conversion of the soluble into the comparatively insoluble form.

Dr. BAIN read a paper on "The Action of Various Drugs and Diets on the Excretion of Nitrogen in Gout." He described a case under his observation which he had carefully investigated and mentioned that he had found that guaiacum markedly increased the elimination of uric acid, and that a vegetable diet had a greater effect in increasing the uric acid than an animal one.

Dr. SANSON asked how it was that the deposits sometimes cleared up and sometimes persisted, and why it was that the deposits did not always cause pain?

Dr. LUFF in reply pointed out that when the alkalinity of the blood, due to sodium bicarbonate, was high the deposits could not be dissolved. Pain was produced when the deposit was rapid and copious. He did not think that necrotic destruction of joint cartilage occurred in cases of true gout, this being characteristic of rheumatoid arthritis.

Dr. BAIN, in reply, suggested that the production of pain depended first on the rapidity of the deposit and secondly on the involvement of sensory nerves.

Obituary.

ROBERT CORY, M.D., F.R.C.P.

THE death is announced of Dr. Robert Cory, on the 19th inst., after an illness of several weeks' duration. Dr. Cory was educated at Pembroke College, Cambridge, and at St. Thomas's Hospital. At Cambridge he obtained honours in the Natural Science Tripos in 1868, graduated B.A. in 1869, M.B. in 1871, and M.A. and M.D. in 1879. For some time he was examiner in Natural Science at Pembroke College. At St. Thomas's Hospital he took the Physical Society's prize for third year's students in 1869, was subsequently appointed house-surgeon and assistant obstetric physician, and at the time of his death was Lecturer on Forensic Medicine to the medical school, and physician in charge of the vaccination department of the hospital. During the Franco-German war he was assistant-surgeon to the Alice Darmstadt Hospital, a temporary hospital constructed by Englishmen, the nursing of which was done by a society established and superintended by the late Princess Alice. On the conclusion of the war he returned to this country, became a member of the Royal College of Surgeons in 1871 and four years later obtained the membership of the Royal College of Physicians, and was elected a Fellow of that body in 1887. Dr. Cory was a teacher of vaccination under the Local Government Board in London and Cambridge, and his practical re-

searches on the subject of the possibility of transmitting syphilis by vaccination, in the course whereof he himself contracted the disease, excited great interest some fifteen years ago, and settled certain moot points in relation thereto. He was a member of Council of the Epidemiological Society, and Stewart Prizeman in Epidemiology in 1888. As just mentioned, Dr. Cory's chief work was in connection with the subject of vaccination. His labours for the Local Government Board in this branch of medicine—the practice and teaching of vaccination—for upwards of twenty-four years (says the *Times*) were of great service to the public and the profession. He was the author of "The Theory and Practice of Vaccination (1897), which he dedicated to the memory of his friend, Sir George Buchanan, F.R.S., and of numerous papers on subjects connected with medicine contributed to "The Reports of the Local Government Board," "The Transactions of the Epidemiological Society," the St. Thomas's Hospital reports, and to the medical journals.

Medical News.

University College Hospital.

THE annual general meeting of the governors and subscribers of the North London or University College Hospital was held last Wednesday in the board room. Lord Monkswell (treasurer of the hospital) moved the adoption of the report, which stated that it was hoped shortly to occupy the new north west wing and central block, and when this was done the south wing of the present hospital would be demolished to make room for the building of the south-east wing. The contributions, under the head of subscriptions, for the past year did not compare favourably with the previous year, and the Chairman added that had it not been for the amount received by way of legacies, he did not know how the hospital could have been carried out. The committee had to look forward this year to increased expenditure owing to the change in the nursing arrangements, and largely increased support was rendered necessary by the fact that the new and larger hospital, now in course of erection, would require, when fully occupied, an annual income amounting to £28,000 or £30,000. The only income upon which the committee could rely at present was £7,500. For many years past they had pressed upon the attention of the public the desirability of permanently endowing beds and cots. The cost for the full endowment of a bed or cot was £2,000, but they would gladly receive this amount by instalments. The report was unanimously adopted.

Royal Colleges of Physicians and Surgeons.

THE following candidates have passed the preliminary conjoint examination honours (in order of merit):—L. A. Andrews, B. T. Brayshay.

Pass (alphabetically)—W. W. Boyce, H. N. Cole, Miss C. H. Colley, E. G. Condon, J. J. Connolly, Charles Cooper, R. F. Cooper, W. J. Cowan, L. Ellenbogen, J. Farrelly, H. W. Forsyth, B. Goldfoot, E. J. Higgins, D. Hutch, C. J. Kean, F. Leyburn, W. Matthews, H. V. McKeogh, F. M. Lorinan, F. MacManus, Timothy O'Donovan, H. E. Redmond, A. O'Reilly, E. Strickland, P. D. Sullivan, Abm. Weinronk, and G. F. Wright.

Society of Apothecaries of London.

THE following candidates passed in March, 1900:—

Surgery.—W. F. C. Bennett (Section II.), Sheffield; R. R. P. S. Bowker, Middlesex Hospital; H. N. Collier, Guy's Hospital; R. V. Cowey (Section I.), St. Mary's Hospital; W. K. S. Hay-Coghlan, St. Mary's Hospital; R. C. Rumbelow, Middlesex Hospital; A. Y. St. Leger (Section II.), Cambridge and St. Mary's Hospital; and T. Young (Sections I. and II.), St. Bartholomew's Hospital.

Medicine.—W. D. French (Section I.), University College Hospital; H. Jessop (Section I.), Birmingham; W. T. Meagher, Cork; A. C. Oliver (Section II.), Charing Cross Hospital; and J. R. Pooler (Section I.), Birmingham.

Forensic Medicine.—W. D. French, University College Hospital; H. Jessop, Birmingham; W. T. Meagher, Cork; J. R. Pooler, Birmingham; and H. F. Willington, Manchester.

Midwifery.—E. F. Lampert, Royal Free Hospital; C. A. Lower, Guy's Hospital and Bristol; F. A. Segreda, Guy's Hospital; and H. P. Shanks, University College Hospital.

The diploma of the Society was granted to the following candidates, entitling them to practise Medicine, Surgery, and Midwifery:—W. F. C. Bennett and W. K. S. Hay-Coghlan.

Notices to Correspondents, Short Letters, &c.

LOCAL REPORTS AND NEWS.—Correspondents desirous of drawing attention to these are requested kindly to mark the newspapers when sending them to the Editor.

K. G. (Torquay).—We have asked our special continental correspondent to reply to your query. The following is his answer:—Biarritz from Easter until after Whitsuntide is usually a very agreeable residence. Good weather and abundant amusements. Excursions of varied interest. Capital golf links. "Country club," with afternoon teas, gymkhanas, &c. Sea bathing and mineral-water baths. As for hotels, on the shore are "The Angletier" and "The Victoria"; in the town near English Church, "The Princess." Each good. And highly recommended, several minutes walk from the sea, amidst gardens and pine forests, the newer "Hotel Biarritz-Salins." Plenty of choice!

VENESECTIONS.

"I had supposed until yesterday, doctor, that the days of the bleeding of patients were past." "And so they are. But what has changed your mind?" "The bill you sent me."

C. and D. S.—It is a common assumption on the part of weak-minded individuals that they are less responsible for their actions than ordinary persons. That undesirable attitude appears to be mainly the outcome of the way in which they have been brought up. One of the chief rules that experts try and inculcate in the understanding of the mentally deficient is the ancient legal maxim, "Sic utere tuo, ut alienum non laedas." That principle underlies most high social and religious codes. We shall be glad to give you a list of books bearing upon the subject.

A. K. (Preston) writes to ask whether any of our readers have had experience of thyroïd gland in alopecia areata. He has tried most of the approved external applications on a man of forty who has been almost entirely bald for two years.

Meetings of the Societies and Lectures.

WEDNESDAY, MARCH 28TH.

DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND (20, Hanover Square, W.).—4.30 p.m. Informal Exhibition of Cases. 5 p.m. Ordinary Meeting.

HUNTERIAN SOCIETY (London Institution, Finsbury Circus).—8.30 p.m. The President: Address. Paper:—Dr. D. Ross: Some Points in the Therapeutics of Gout.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.). 5 p.m. Mr. J. Hutchinson: Clinical Lecture:—The Present-day Treatment of Syphilis. 6 p.m. Annual Meeting.

THURSDAY, MARCH 29TH.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.—5 p.m. Dr. W. B. Cheadle: Cirrhoses of the Liver. (Lumleian Lecture).

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies Street, W.C.).—4 p.m. Mr. J. Hutchinson: Consultation. (Surgical.)

MONDAY, APRIL 2ND.

ODONTOLOGICAL SOCIETY OF GREAT BRITAIN (40, Leicester Square, W.C.). Mr. G. J. Goldie: The X-rays in the Practice of Dentistry. Mr. H. Baldwin: A Case of Necrosis. Mr. H. G. Read: A New Saliva Tube.

THURSDAY, APRIL 5TH.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Tichborne Street, Edgware Road, W.).—A Discussion on "Purulent Nasal Discharges and their Treatment" will be opened by Mr. Edmund Roughton. Dr. Dundas Grant, Dr. Wm. Hill, Dr. Herbert Tilley, and others will take part.

Appointments.

ADENEY, E. L., M.D., M.R.C.S., Physician to the General Hospital, Tunbridge Wells.
ALDERSON, WILFRED E., M.D., M.S.Durh., Honorary Assistant Surgeon, Fleming Memorial Hospital for Children, Newcastle-on-Tyne.
BOYD, JOHN J., M.B., Ch.M.Glasg., D.P.H.Cantab., Assistant Medical Officer of Health for the Borough and Port of Southampton.
BROOK, W. H. B., M.D.Lond., F.R.C.S.Eng., Coroner for the Lincoln North District.
CAMERON, H. C., M.D.Glasg., Chair of Clinical Surgery in the University of Glasgow.
COOPER, C.E., M.B., B.C.Cantab., Medical Officer of Health for the Ivybridge Urban District, vice J. M. Randle, resigned.
GOLDIE, W. H., M.D., C.M.Édin., Registrar to the Chelsea Hospital for Women, Fulham Road, London, S.W.
HAMILTON, DAVID LIVINGSTONE, L.E.C.P., F.R.C.S.Édin., L.F.P.S.Glasg., Medical Officer for the Timsbury District by the Clutton Board of Guardians.
HARCOURT, J. C., L.E.C.P.Lond., M.R.C.S., Assistant Medical Superintendent for the Infirmary of the City of London Union.
MUSSEN, A. A., M.D., D.P.H., Assistant Medical Officer of Health for the City of Liverpool, vice E. P. Mamby, resigned.
PARDINGTON, G. L., M.D.Durh., L.E.C.P.Lond., M.R.C.S., Physician to the General Hospital, Tunbridge Wells.
RIX, B., M.R.C.S., L.S.A., Surgeon to the General Hospital, Tunbridge Wells.
TARBET, P. R., L.R.C.P.Lond., M.R.C.S., Senior Assistant Medical Officer for the Infirmary of the Parish of St. Pancras.
THOMAS, A. H., M.B., Ch.B.Édin., Medical Officer for the Aldborough Sanitary District of the Great Ouseburn Union, vice J. Sedgwick, resigned.

THOMSON, H. CAMPBELL, M.D., M.B.C.P.Lond., Assistant Physician to the Middlesex Hospital.

Vacancies.

Birmingham General Dispensary.—Vacancy on the staff of Resident Surgeon, unmarried. Salary £150 per annum. £30 a year allowed for cab hire, and furnished rooms, fire, lights, and attendance.
Cardiff Infirmary.—Assistant House Physician for six months. Salary at the rate of £50 per annum, with board, washing, and apartments. Also Resident Medical Officer for three years. Salary £100 per annum, with board, washing, and furnished apartments.
Clonmel District Lunatic Asylum.—Assistant Medical Officer. Salary £125 per annum, with £50 in cash in lieu of rations, furnished apartments &c. Applications to Resident Medical Superintendent. (See Advt.)
Down (County) District Asylum, Downpatrick.—Assistant Medical Officer, unmarried. Salary £100 per annum with furnished apartments, board, washin, and attendance. (See Advt.)
Hospital for Sick Children, Great Ormond Street, Bloomsbury, London.—House Physician, six months, unmarried. Salary £20, with board and residence in the hospital.
Hulme Dispensary, Dale Street, Stetford Road, Manchester.—House Surgeons. Salary £150 per annum, with apartments, attendance, coal, and gas.
Italian Hospital, Queen's Square, London, W.C.—House Surgeon. Salary £50 per annum, with board, residence, and laundry.
London County Asylum, Horton. Medical Superintendent, Horton Asylum, Epsom, now in course of erection. Salary £1,000 per annum, with unfurnished house, rates, taxes, and water supply free. Clerk of Asylums Committee, 6, Waterloo Place, London, S.W.
Metropolitan Asylums Board.—Four Assistant Medical Officers at the Fever and Small-pox Hospitals, unmarried. Salary £160 per annum the first year, and conditionally £180 the second, and £200 the third and subsequent years, with board, lodging, attendance, and washing, subject to statutory deductions. Offices of the Board, corner of Carmelite Street, Embankment, E.C.
New Zealand Public Lunatic Asylums.—Two Assistant Medical Officers, unmarried. Salary £250, with board, lodging, and washing. Apply to the Agent-General for New Zealand, 13, Victoria Street, London, S.W.
Peckham House Asylum, Peckham.—Junior Assistant Medical Officer. Salary £120 per annum, with board and lodging.
Ramsgate and St. Lawrence Royal Dispensary, and the General Hospital and Seamen's Infirmary.—Resident Medical Officer, unmarried. Salary £100 per annum, with furnished apartments, board, and attendance. £10 allowed for substitute during annual holiday.
Royal Free Hospital, Gray's Inn Road, London.—Senior Resident Medical Officer for 12 months. Salary £100, with board, residence, and washing.
Seamen's Hospital, Society (Dreadnought), Greenwich, S.E.—House Physician for Dreadnought Hospital, Greenwich. Salary £75 per annum, with board and residence.
Stockport Infirmary.—Assistant House and Visiting Surgeon. Salary £70 per annum, with board, washing, and residence.
Teignmouth Hospital, South Devon.—House Surgeon. Salary £50 a year, with board, lodging, and washing. £6 per annum allowed in lieu of stimulants.
West Bromwich District Hospital.—Resident Assistant House Surgeon. Salary £50 per annum, with board, &c.
Western-super-Mare Hospital.—House Surgeon, unmarried. Salary £80 per annum, with board and residence in the hospital.
Wolverhampton and Staffordshire General Hospital, Wolverhampton.—Assistant House Physician for six months. Honorarium at the rate of £50 per annum, and board, lodging, and washing provided.
Worcester General Infirmary.—Assistant House Surgeon and Dispenser for two years, unmarried. Salary £70 per annum, with board, residence, and washing.

Births.

COX-MOORE.—On March 18th, the wife of Edward W. Cox-Moore, L.D.S., Bloomsbury Square, W.C., of a daughter.
ECCLES.—On March 24th, at Harley Street, W., the wife of W. McAdam Eccles, M.S.Lond., F.R.C.S.Eng., of a daughter.
FREEMAN.—On March 18th, at Windermere Villas, Earlsfield, S.W., the wife of C. D. Freeman, M.R.C.S., L.R.C.P., L.S.A.Lond., of a daughter.
ISAACS.—On March 16th, at Sinclair Road, Kensington, the wife of E. Percival Isaacs, L.R.C.P., M.R.C.S., of a daughter.
THORNE.—On March 18th, at The Glen, Dore, near Sheffield, the wife of Charles A. Thorne, L.R.C.P., L.R.C.S., of a son.
TYSON.—On March 15th, at Folkestone, the wife of W. J. Tyson, M.D., of a daughter.

Marriages.

FINCH-BARRETT.—On March 14th, at St. John Baptist's, Kensington, Ernest J. Finch, Surgeon R.N., H.M.S. *Hussar*, to Dorothy, third daughter of Alfred E. Barrett, Holland Park Avenue W., and Grimston, Norfolk.

Deaths.

CORY.—On March 19th, Robert Cory, M.A., M.D.Cantab., F.R.C.P.Lond., of Lambeth Palace Board, St. Thomas's Hospital.
FOULDS.—On March 12th, Henry John Foulds, M.R.C.S.Eng., at Derby.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXX.

WEDNESDAY, APRIL 4, 1900.

No. 14.

The Lettsomian Lectures.

PRACTICAL OBSERVATIONS ON CANCER OF THE BREAST. (a)

By Sir WILLIAM M. BANKS, LL.D., F.R.C.S.,

Surgeon to the Liverpool Royal Infirmary; Emeritus Professor of Anatomy in University College, Liverpool.

LECTURE III.

THE PARASITIC AND INFECTIVE VIEWS OF CANCER.

It would be out of place here to enter into a detailed history of the early searchings after truth in this matter for, however praiseworthy, nothing definite came of them. The first notable step in advance was made by Dr. Russell, of Edinburgh, in 1890. In the *British Medical Journal* for December of that year will be found a paper by him modestly entitled "A Characteristic Organism of Cancer." Seeing that they were well displayed by staining with fuchsin, he termed them "Fuchsin Bodies." The attachment of men's names to all sorts of silly little discoveries and operations is much to be deprecated, but so important a move in the right direction might well be commemorated by designating them Russell's bodies. He described them both as intra-cellular and extra-cellular, and, what is of much importance, he held them to be blasto-mycetes, a variety of saccharo-mycetes, or yeasts. The general opinion was distinctly against him, but in the "Annales de l'Institut Pasteur" for 1892 appeared a paper by Professor Soudakewitch, of Kieff—*Parasitisme intra-cellulaire des néoplasies cancéreuses*—describing and figuring bodies obviously very similar to Russell's bodies, and in the same year (*Journal of Pathology*) a very important contribution by Armand Ruffer containing confirmatory evidence. Preparations illustrating both these papers were shown to Metchnikoff, and that distinguished pathologist gave it as his opinion that the bodies were "parasitic protozoa." This at once altered the venue from the vegetable to the animal kingdom. In this country the fuller investigation of the parasite has been very ably carried on by Mr. Plimmer, of St. Mary's Hospital. In the so-called "cancer" number of the *Practitioner*, already referred to, will be found a review by him of the whole question up to April, 1899. It is a model of clear, unbiassed writing, and the description of the general structure of cancer and methods of examination most admirable.

For a considerable time my friend and old pupil, Dr. Buchanan, formerly assistant demonstrator of physiology in University College, Liverpool, and now physician to the Liverpool Consumption Hospital, has been investigating these parasites, and he recently (January, 1900) contributed a paper upon them to the pathological section of the Liverpool Medical Society. I have had the pleasure of going over all his work with him, and I

cannot help coming to the conclusion that the bodies described as parasites are bodies *sui generis*—special organisms—and are not degenerations of cell protoplasm or of non-parasitic cell inclusions. It seems as if the almost daily increasing evidence is now too strong to permit of our simply listening to those sceptical persons who merely deny their existence without having even hunted for them or even seen them. Where these bodies come from, where they go or what they do is nothing to the point for the moment. The question is, Do they exist? I have been convinced that they do.

A very reasonable question on the part of the doubter is this:—Cannot these said parasites be found in structures other than carcinomata and sarcomata? After Russell's pronouncement many investigators said that this was so, but, as time has gone on, they have failed so far to prove their case. On the other hand, Plimmer's most extensive enquiries have gone all the other way. During the six years preceding 1899 he had examined microscopically 1,278 cancers taken as they came from many parts and organs, and of all possible varieties. Out of this number he has found the parasite in 1,130 instances. Of the cases in which he failed to find them 63 were densely fibrous and atrophic, actually in process of spontaneous cure, and 23 were so degenerated that they would not stain. He has examined by his method gummata, typical histoid tumours of all kinds, tuberculous growths, glands, actinomycotic growths, epithelium which had been artificially irritated and normal tissues, and never in man, in any instances, has he seen any intra or extra-cellular bodies like the parasitic bodies he describes or which had their reactions.

The opinion of Metchnikoff that the parasitic bodies were protozoa was for a while the dominant one with probably all investigators. But Russell's view that they were blastomycetes has been revived by two eminent Italian savants, whose names are at present in the mouths of all who are interested in the question. One of these is Professor Sanfelice, director of the Institute of Hygiene in the Royal University of Cagliari, and the other is Professor Roncali, of Rome, the former working largely from the experimental point of view, and the latter from the histological. Now their opinion is distinctly that the parasites are blastomycetes. Plimmer, however, still holds to the protozoal view as the better for provisional acceptance until more is known. It is clear that the question is not a vital one, and that, at all events, it does not in any way hinder the experimental work now going on, and having for its object to prove that these bodies, when separated from the other constituents of a cancerous growth when cultivated and the cultivated products implanted in animals, will be reproduced in these animals and originate cancer in them.

What, then, is the appearance of these parasites? As I have seen them in Dr. Buchanan's sections they are round cells possessing what would correspond to a central nucleus, a surrounding mass of indefinite protoplasm, and an enveloping cell wall or enclosing capsule of some kind. These general features have been brought out by different investigators in different ways, but the plates published by them show a great uniformity in the general appearance of the parasite. The method of display pursued by Dr. Buchanan is this. As fixing reagents he used (1) a

(a) Delivered before the Medical Society of London, Monday, April 2nd, 1900.

saturated solution of perchloride of mercury, in .75 salt solution, in which the specimen was placed for twenty-four hours and then transferred to methylated spirit, to which had been added a few drops of saturated solution of iodine in alcohol; (2) bichromate of ammonia; (3) Fleming's solution. As regards staining processes he found the Ehrlich-Biondi triple stain very good, but apt to fade too quickly. Another method: stain with Ehrlich's acid hematoxylin, wash in distilled water, then "blue" in distilled water rendered faintly alkaline with lithium carbonate. Again another: stain with saturated aqueous solution of fuschin S. or carbol-fuschin S., then dehydrate in absolute alcohol strongly tinged with aurantia, clear in clove oil tinged with aurantia, and mount in xylobalsam. The size of the cells is very various. Plimmer reckons them at from .004 mm. to .04 cm., or even more. I have seen some which have a circumferential row of fine dots disposed just within the capsule and others in which the nucleus has an appearance of being split up and the portions somewhat twisted. Again there are some which have most delicate lines, radiating from the centre to the circumference. Some writers have described and figured quite an array of different forms of the parasite, but personally, possibly owing to my want of skill, I have not been able to make sure to myself of more than the varieties mentioned above. As far as regards their mode of reproduction, Plimmer is of opinion that it is by division into two by the process of budding; or the nucleus divides into two while the capsule throws in septa which meet between these two halves, and so divide the parasite into two. Dr. Buchanan has never been certain of their mode of propagation, and in his specimens I have not been able either to make sure of anything definite as regards this point. I think Plimmer's immense experience makes his opinion the one to be received, at the moment at all events.

I would like here to quote some of Dr. Buchanan's conclusions. "By careful comparison I found in these bodies a constant recurrence of definite structure, a beauty and regularity of design marked by stages of enlargement and growth with many evidences of a truly developmental process. Degenerative processes are essentially irregular, with no definite recurrence of form and with no beauty of design. I entertained two ideas (1) that if these bodies were truly parasitic from without, two conditions were necessary for their entrance into cells (a) either they must be capable of movement constituting change of locality; or (b) the (epithelial) cell must be capable of movement sufficient for it to enclose the parasite, or a combination of both conditions at one time. (2) That, as a cancer is progressive in growth, the parasite must develop *in situ*; if it do not then, if it be an exciting cause, the growth must eventually cease." He then goes on to express his opinion that the parasite is capable of movement, and that its appearance in many cases is due to definite change of shape, such is generally recognised in amoeboid cells—that in its young state it enters a cell and there develops, dividing and re-dividing into a number of spore-like bodies which may eventually fill and swell the capsule into a cyst in which the spore bodies lie like a mulberry mass and the cyst resembles a sporocyst; that these spores eventually find exit from the capsule, probably through a special aperture, whence they infect other cells; that the parasites are probably fertilised to ensure reproduction, although the method has not yet been demonstrated; that they are living entities introduced from without to whom the cancer cell occupies the position of a host.

It has been matter of wonder why, if the parasites are such well-defined bodies, they have not been noticed long ago. But the fact is that on any average tumour they are comparatively few in number, and have to be searched for, and (a most important point) they are not to be found in the hard centre of a scirrhous mass at all, but only at the growing edges of a tumour. The centre is largely composed of fibrous tissue and cells in course of degeneration. It is the inactive part of the tumour, where nature is making an effort at cure. All the vigorous proliferating epithelium is at the margin and it is only

inside active cells that the parasite is found. Then the processes of staining required to display the parasites are very delicate and complicated, and are really only the product of the last few years.

Ignoring, then, the question of whether the parasites are to be considered as yeasts, and to be named blastomycetes, or whether they are protozoa or coccidia, has anything experimental been done with them? I will begin with some recent observations made by my friend, Mr. Keith W. Monsarrat, assistant-surgeon to the Liverpool Royal Infirmary, in order, if possible, to confirm the observations of Sanfelice, Roncali, and others. Having obtained a fresh cancerous tumour he made into its outlying parts a series of some twenty or thirty incisions with a sterilised knife. Scrapings were taken from the edges of these incisions and inoculated on Turcose Agar. From this subcultures grown on Wort Agar and Wort Bouillon, were employed, and were plentiful after twenty-four hours' incubation at 37° C. From this, again, guinea pigs were inoculated by intraperitoneal injection of 1 cc. of a culture forty-eight hours old. They showed no symptoms of illness, and were killed at periods from two to six weeks after the injection. On opening the abdomen the omentum and general peritoneal surface were found to be studded with nodules from the size of a pea to that of a pin's head; to the naked eye nodules were visible in the lungs, liver, spleen, and kidneys. The parasites were found reproduced in the cultivations and in the inoculation growths. Mr. Monsarrat employed the following staining process for them, which he believes very accurately differentiates them and picks them out from surrounding structures. Fix with saturated solution of perchloride of mercury and harden in alcohol; place in a etic carmine for half an hour, and then wash in water; followed by two minutes in methyl violet 1 per cent. and two minutes in picric acid 25.00; then transfer to clove oil until no more methyl violet will come off. The primary growths on the peritoneum are composed of proliferated endothelial cells. The organisms are present in considerable numbers, some within the cells, but most outside them. This is contrary to what occurs in primary cancers in the human body, where the extracellular parasites are few in number compared with the intracellular. In many of the nodules there is some attempt at the formation of a connective tissue capsule, and in others the central parts are broken down. In the lungs the nodules are made up of endothelial cells; in each nodule there are organisms present and usually centrally situated. In the liver and spleen the nodules are very similar in appearance to the primary omental growths. The origin of the cells composing them is doubtful. In the kidney, where again the nodules are of endothelial origin, the cells are derived from those lining the Malpighian corpuscles and tubules. In no case was there any alveolar arrangement of the cells or any appearance resembling the endotheliomata of man.

With regard to the cultures the appearances agreed in the main with those described by Sanfelice and Plimmer. Fresh specimens from them are spherical from 4 to 10 mm. in diameter, and in most instances take an aniline chromatin stain diffusely.

I think we may regard Mr. Monsarrat's work as quite confirmative of what Mr. Plimmer has detailed with such admirable clearness and precision in the cancer number of the *Practitioner*. There his own experiments on the same lines are to be found, and there the fullest directions for staining according to the methods which he has found the best and which produce specimens at once beautiful and convincing. To anyone who wishes to know about the parasites of cancer this article is invaluable. But what has been briefly touched upon in this description regarding the results of the inoculation of animals with the parasite has been far outdone by Sanfelice, who began his researches in 1894, and whose last conclusions were published in 1899. Dr. Russel has written a most admirable summary of Sanfelice's last experiments (the *Lancet*, April 29th, 1899). If you will allow me, I will give you the barest outline of them. Sanfelice was investigating the character of blastomycetes, when he

found that some of them were pathogenic to animals and caused the growth of tumours in them. He selected a special organism for purposes of experiment, which he denominated the *saccharomyces neoformans*. Inoculations of guinea pigs with it produced a general infection of the animal, with the formation of tumours consisting partly of masses of the parasite, and partly of proliferation of the cells of the part. The general microscopic appearance of the new growths seems to have been pretty much what Plimmer has recorded as the result of his experiments and what Monsarrat has described as produced in his, as we have just noted. Bodies were perceived having the appearance of what the earlier investigators described as coccidia (protozoa), and what Russell had described and regarded as blastomycetes. These bodies, as found in the tumours, differed somewhat from those in the cultures as regards appearance. He inoculated with pure cultures of the *saccharomyces neoformans* certain cats, and found typical forms of Russell's bodies in the tissues. To make sure of the matter he investigated the tissues of normal cats, but no parasites were found in them, although this occurred invariably after the injection of the special blastomycetes. The cats, in short, were very susceptible. Cats, by the way, are liable to cancer although not nearly in the same proportion as geldings. Next the experimenter proceeded to pass the blastomycetes with which he was experimenting through a number of dogs—that is, from dog to dog. In two instances something very specially tending towards malignancy was produced. In one case the dog was inoculated in the two posterior nipples with the blastomycetes which had been passed through several dogs. The animal died 10 months later with tumours in both teats, showing retraction of the nipples and tacking down of the skin, with secondary growths in the inguinal and abdominal glands. All these showed the type of adeno-carcinoma. In the other case a dog which was inoculated in both testicles died with adeno-carcinoma of these organs, with secondary growths in the neighbourhood of the penis and glands. If all this be true it will constitute a remarkable advance in the history of the parasitic view of cancer, more especially when it is considered that these experiments were conducted with cultures made from an organism obtained from a fruit juice. These he found much more active than the cultures made from cancer. I have seen a microscopic section of a tumour produced after passing a blastomycetes through many animals, but I confess I could not recognise in it a typical carcinoma, although it assuredly tended in that direction, and had a certain amount of connective tissue in its composition.

If I were now asked what is the impression produced on my mind by what I have seen and read about the so-called Russell's bodies or cancer parasites, I would put it briefly thus:—(1) There is plainly a structure of a definite nature which is found in man at the marginal or growing edges of carcinomata. It is not found in any healthy tissue nor in any other neoplasm except sarcoma. It used to be regarded as a protozoan or coccidium, but most investigators seem now to regard it (as Russell did at first) as a blastomycetes which is a form of *saccharomyces*, reckoned to be a development stage of certain fungi. Most parasites are inside the epithelial cancer cells, some are outside. There is a strong probability that they spread by sporing, although much more knowledge on this point is wanted. How they get into or originate in the human body is not known, and what action, if any, they have upon the epithelial cells has not yet been demonstrated. But, admitting an action, it is doubtless that of an irritant to them, which causes them to proliferate. (2) There is no doubt that from the parasites cultivations in certain media can be made, and that, when such are injected into animals, growths are produced in them, mostly of a fatal character, which contain these parasites. (3) Sanfelice asserts that he can produce the same results in animals by the injection of a blastomycetes obtained from a fruit juice. Furthermore that by passing the parasites through a series of animals a tumour is at length produced which is an adenocarcinoma. On these points I cannot say any-

thing of my own knowledge beyond what I have said a few sentences back regarding a section of such a tumour which I have seen. (4) That as yet there is no clear and indisputable proof of the infectivity of cancer; that consequently any strong assertions to that effect or any statements that surgeons infect wounds by disseminating cancer products through them during operations are not justified. That, on the other hand, the possibility of this infectivity must not be sneered at or treated lightly in view of the remarkable information which has been obtained during the last few years concerning the cancer parasite and certain of its attributes. This is not the time for positive assertion. This is the time for patient experiment and the collection of facts.

(To be continued.)

Three Lectures

ON

THE SURGERY OF THE STOMACH. (a)

By A. MAYO ROBSON, F.R.C.S.ENG.,

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ABSTRACT OF LECTURE II. (b)

PERFORATION.

ALL cases of perforation naturally range themselves into two classes, the acute and sub-acute. In acute perforation there are the signs of a peritoneal catastrophe, usually supervening on the symptoms of gastric ulcer, there being immediate severe collapse with intense pain followed by a rapidly spreading lethal peritonitis. In the greater number of cases of perforation the actual rupture occurs when the stomach is full or moderately distended, and as the rupture usually takes place on the anterior surface, the contents are poured into the great sac of the peritoneum, flowing along the depression between the colon and stomach into the right or left lumbar pouch; but if the stomach contents be abundant they flow over the omentum and pass into the pelvis at once. When an ulcer perforates the posterior surface of the stomach the lesser peritoneal cavity is at once invaded, and if the stomach contents be abundant, the fluid pours into the right kidney pouch through the foramen of Winslow and so involves the general peritoneal cavity. Under these circumstances, where there are no limiting adhesions the symptoms are very acute, and operation to be successful must be undertaken at the earliest possible moment, as every additional hour increases the risk of failure. If perforation occurs with the stomach empty or only containing a small amount, protective adhesions may be formed in immediate contiguity to the ulcer, and recovery may occur; for although the perforation of a gastric ulcer is almost universally fatal we must not forget that in a few exceptional cases the rule does not hold. In perforation following on malignant disease there are the usual symptoms and signs of cancer of the stomach, with the sudden supervention of acute symptoms of perforation.

In subacute perforation there is more difficulty in making a diagnosis as the symptoms are less definite. There may be pain, followed by sickness and faintness, perhaps by vomiting, with slowly extending tenderness of the abdomen and distension; but all these conditions are much less marked in the early stage than they are in the acute variety, though they

(a) Delivered in the Theatre of the Royal College of Surgeons of England on March 7th, 1900.

(b) Lecture I. was published in THE MEDICAL PRESS AND CIRCULAR of March 28th, 1900.

may at the end of two or three days develop rapidly and end the patient's life in a few hours, or the inflammation may very slowly extend, leading to localised abscess, which tends to extend in various directions. In these cases there are many varieties in the combination of signs and symptoms, according to the direction in which the localised inflammatory collection travels. Thus we may have subphrenic abscess on the right or left side, pancreatic abscess, hepatic abscess, retro-peritoneal abscess pointing in various directions, and fistula between the stomach and intestines or between the stomach and gall-bladder, or even on to the parietes. In this secondary perforation the course of the pus will be either as in primary perforation of the posterior wall into the small sac of the peritoneum and left subphrenic space, or as in anterior perforation into the great peritoneal sac and the right subphrenic space.

But between these acute and chronic perforations there is a third variety, where perforation occurs and a small amount of fluid escapes, which extravasation is limited by adhesions at some distance from the perforation. Clinical and anatomical explanations would seem to account for the varieties one may meet with in perforating gastric ulcer. According to Maydl, one-fifth of all subphrenic abscesses have a gastric origin, and of these 95 per cent. are the result of ulcers.

Treatment.—Whatever opinions there may be concerning the treatment of some of the other complications of gastric ulcer, such as hemorrhage, concerning the treatment of perforation there cannot be two opinions. Surgery, and surgery alone, holds out practically the only hope of cure, and though in the first 100 cases the rate of mortality was something like from 70 to 80 per cent. even in those reported, and must have been still higher if all the failures as well as successes had been chronicled, yet later results show a steadily decreasing mortality. The greater success of recent cases distinctly proves that time is the chief feature.

The details of operation in cases of perforation are of great importance. Everything should be done to save shock for the collapse may, and probably will, be severe.

If the ulcer be not discovered on the anterior wall or near the lesser curvature the lesser cavity of the peritoneum should be explored by tearing a slit in the gastro-colic omentum. Should the lesser cavity be free from fluid, or the lining walls be free from infection, it is not necessary to proceed further in that direction, and the pylorus must then be carefully examined. As soon as the perforation is discovered it must be sutured by apposition of the margins, or by turning the edges inward and by inserting a row of Lembert's sutures through the peritoneal coat over the site of perforation, and, if practicable, superimposing a second row of stitches; but owing to the unhealthy and sometimes indurated condition of the margins of the ulcer, this is more easily described than done. If the line of suturing be thought to be insecure, a flap of omentum may easily be brought up and stitched over the opening. This I have successfully done in several cases, and as it involves very little time and gives a decided sense of security, I think it is not a bad rule to follow in most cases.

Excision of the ulcer is, as a rule, unnecessary and involves a waste of time, but in some cases it may make suturing easier. Having closed the ulcer, the cleansing of the peritoneal cavity must be thoroughly and methodically carried out and if the extravasation of fluids be limited, as in a case that I saw within six hours of rupture and where only the right side of the abdomen was soiled, general irrigation is undesirable and may do more harm than good, but the parts should be very carefully wiped by soft sponges, great care being taken to cleanse the various folds and the

space between the liver and diaphragm. When the effusion is more extensive and the peritoneal cavity has been generally soiled, irrigation is undoubtedly the best means of cleansing it. I am quite aware that some surgeons disagree *in toto* with flushing the peritoneum, preferring always to wipe rather than to flush, but my own feeling is that we should select our cases and where the soiling is limited wipe, but where it is general flush. The most difficult region to purify is that between the liver and diaphragm.

Operation in chronic perforation practically resolves itself into the treatment of peritoneal abscess wherever it may be found; but in case of chronic or subacute perforation from gastric ulcer in by far the greater number of cases the abscess is under the diaphragm. It is curious that an abscess of this kind seldom bursts into the general peritoneal cavity. With regard to the site of operation that will depend entirely on the position of the pus.

GASTRIC FISTULA.

Gastric fistula, a sequel of perforation, may be found occasionally on the surface of the abdomen, very rarely in the loin, but not infrequently between the stomach and adjoining organs. It may be pathological or traumatic.

The symptoms vary according to the cause and the site of the fistula. If it be between the stomach and upper bowel the symptoms may be slight or absent, but if it be between the stomach and the large bowel the food will pass too rapidly through the alimentary canal and be parted with before absorption is adequate for nutrition, and, on the other hand, gases from the colon entering the stomach will give rise to foetid eructations, at times to feculent vomiting, and always to chronic dyspepsia. Fistulae on the surface of the abdomen, if small, may cause little loss of health, but if extensive the leakage from the stomach of food and gastric juice leads to great distress from the soreness of the skin around the fistula, and to loss of flesh from the waste of food.

Diagnosis.—As a rule, except in surface fistulae, diagnosis can only be made after opening the abdomen, but if unaltered or slightly altered food be seen in the faeces after a history pointing to simple or malignant ulceration of the stomach, a fistula between the stomach and the colon would be suspected, especially if foetid eructations or feculent vomiting occurred from time to time. The inability to distend the stomach with air pumped through an œsophageal tube would help in the diagnosis.

Treatment.—In simple internal fistulae exploration by abdominal section and closure of the two openings may be done, as in the cases previously referred to. In malignant disease partial gastrectomy and enterectomy might possibly be performed if the disease could be discovered in time, but such a communication would probably mean advanced disease and secondary infection, and would, therefore, as a rule, be beyond operative treatment. Surface fistulae can be closed readily by plastic procedures if they do not close spontaneously under careful dressing and rest.

PERIGASTRITIS AND ADHESIONS.

Adhesions of the stomach and pylorus to neighbouring organs are a common result of perigastritis, the causes of which may be extrinsic or intrinsic. Among the extrinsic causes are gall-stones, tuberculous peritonitis, local peritonitis from intestinal ulceration or from malignant growths in adjoining organs, typhoid fever, and possibly other fevers. Among the intrinsic causes ulceration is by far the most frequent, though cancer and syphilis of the stomach must also be included. Though at the time adhesions, the result of perigastritis, are conservative and may frequently result in the saving of life by limiting peritonitis, the result of perforation or of bacterial infection due to ulcer, yet later such

adhesions may lead to great functional disturbance by interfering with the motor activity of the stomach, and causing pain, disability, and other ailments. Not only are these disturbances caused by adhesions of a functional nature, producing dyspepsia and so-called visceral neuroses, but not infrequently dilatation of the stomach, vomiting, severe pain, and great loss of flesh may result.

Adhesions are found around the stomach in about 5 per cent. of all necropsies, and about 40 per cent. of all cases of ulcer of the stomach are associated with adhesions. My experience in a very considerable number of abdominal sections, about five hundred of which have been in the upper abdominal region, is that pyloric adhesions are very much more common than is usually supposed, and that their importance is greater than is generally recognised, even at the time of operation. This is especially the case in cholelithiasis, where I am accustomed to find gastric dilatation as a regular sequence of gall-stones, and to look for it as an ordinary concomitant sign; and in such cases it is almost always due to adhesions of the pylorus to the gall-bladder and liver. Sometimes the adhesions may be strictly limited to the pylorus and gall-bladder leading to a characteristic train of symptoms. At other times they may extend from the pylorus along the lesser curvature of the stomach, fixing the upper border of the stomach firmly to the gall-bladder, cystic duct, and under surface of the liver. When the pylorus is tied up in this abnormal position, not only are normal movements of the pylorus and stomach interfered with but the food has to be forced out at a higher level, and when the pylorus is alone fixed a kink forms, leading soon to well-marked dilatation with flatulence, chronic dyspepsia, and loss of flesh. Where perigastritis is due to ulceration the adhesions are only found over the site of the ulcer, and if this be at the pylorus a double difficulty is presented, for not only is there fixation of the pylorus at an abnormally high level but the pyloric orifice itself becomes stenosed from the contraction due to the healing of the ulcer. If the ulcer happens to be on the anterior wall of the stomach it may lead to hour-glass contraction. I find that I have operated on 47 cases of stomach disorder where adhesions alone or adhesions associated with some other disease such as gall-stones, led to serious dyspepsia or other digestive derangements and where the removal of the adhesions was followed by great relief or cure of the symptoms. The symptoms vary according to the site and cause of the disease, from mere dyspepsia to serious dyspepsia.

Although cancer is a well-recognised cause of perigastritis in every region of the stomach, the symptoms from adhesions are merged in the more serious ailment; it is therefore unnecessary that I should further consider them at this moment, except to say that they seriously add to the difficulty and danger of pylorotomy or partial gastrectomy.

The diagnosis in these cases rests on a careful consideration of the previous history, together with the presence of well-marked signs and symptoms, so that it is not generally difficult. There will usually be a history of gall-stones, typhoid fever, ulcer of the pylorus, or some local peritonitis in the pyloric region, months or years previously. This will have been followed by indefinite dyspepsia and flatulence, which later takes a very definite shape, consisting of discomfort and pain after food, especially after a full meal, so that the patient prefers to take several small repasts rather than one large meal. The pain and discomfort are at once relieved by the recumbent posture, so that a necessity to lie down or rest after every meal is suggestive. Relief is frequently found by the wearing of a belt and this is usually discovered by the patient before advice is sought. The pain is

often of a dragging character. At times it may be acute, and it is increased or brought on by lifting or reaching, say, to adjust a picture. Walking or any active exertion may bring on discomfort and pain; hence active exertion is shunned, and inability to perform ordinary duties is complained of. When dilatation of the stomach is well marked there may be loss of flesh and vomiting every few days, often in large quantity.

Besides the ordinary signs of dilatation of the stomach and the tenderness between the umbilicus and the ninth costal cartilage, as shown by the rigid right rectus, there is an important physical sign to be obtained by distending the stomach with gas, and that is, the cavity of the stomach is found to extend further to the right and higher than normal. An entire cessation of pain and freedom from dyspeptic troubles if the patient be confined to bed is suggestive, for it will be seen that under these circumstances the higher level of the pylorus is done away with and the recumbent posture prevents the dragging of adhesions; but, after all, an exploratory operation is the only way of setting doubt at rest, and if these distressing symptoms have resisted long-continued medical treatment a surgical operation is clearly justifiable, though doubtless in some of the less severe forms careful medical treatment may lead to an amelioration of symptoms and may give such marked relief that an operation will not be called for. Relief may be obtained by advising the patient to take small meals and to avoid bulky and fermentable foods such as potatoes and bread, to rest after meals, and to wear a well-fitting abdominal belt. The natural cure, in some cases where there has been no operation, is probably due to the stretching of adhesions and to their absorption if the exciting cause has fortunately been removed; but in the more severe cases, where the adhesions are almost universal, such a fortunate termination of symptoms is scarcely to be hoped for, and in some cases the adhesions are so extreme that nothing short of gastro-enterostomy can prove of any avail.

HOURL-GLASS CONTRACTION.

Hour-glass contraction is generally considered among the rarer diseases of the stomach, but my recent experience would lead me to believe that it is much more common than is usually thought, for I have operated on no less than six cases within a year. As its name implies, hour-glass contraction is a division of the cavity of the stomach into two compartments, but in one case on which I operated the cavity was actually divided into three.

The chief cause of hour-glass contraction is cicatricial contraction of a chronic ulcer, but the bipartite condition of the stomach may also be due to perigastritis and the subsequent contraction of a band of lymph, or to adhesions on the outside of the stomach. It is said at times to be congenital.

Treatment.—With reference to early medical treatment I have not much to say, as in all probability it will be only in the later stages that the surgeon will be asked to give an opinion. Lavage and careful dieting will give relief, but the limit is soon reached if constriction be well marked, and as soon as marked loss of flesh is occurring despite careful medical attention, medical treatment should give place to surgical treatment. After opening the abdomen the stomach must be carefully examined and on the condition found will depend the exact line of treatment to be pursued. If adhesions be the cause of stricture they must be divided, and if after this the communication between the two cavities be sufficiently free the abdomen may be closed. If the stricture be cicatricial its calibre may be easily felt by pinching it up between the finger and thumb, when the lumen will be felt between the finger tips.

Three courses are now open: (1) gastropasty; (2) gastro-gastrostomy; and (3) gastro-enterostomy.

1. Gastropasty is the operation that I have performed in all my cases and to facilitate its performance I have modified the operation by stitching up the longitudinal incision transversely over a large decalcified bone bobbin, thus making an opening between the two cavities from one-and-a-half to two inches in diameter. Either a catgut suture may be employed for the mucous margin and a silk suture for the serous surfaces, or silk sutures may be employed for both. The operation can, of course, be performed by simple sutures without the bobbin, but I prefer to employ the bobbin in order to be sure of having the new opening sufficiently large.

2. "Gastro-gastrostomy" seems a good term to apply to the operation for making an artificial opening between the two cavities of the stomach. It can be performed either by simple suture or with the help of a bone bobbin as a splint or by means of Laplace's forceps, but in this situation I would not advise the use of a metal button as it would have no chance of escaping, and might lead to subsequent trouble.

3. Gastro-enterostomy between the proximal cavity and the jejunum would leave the second cavity with its foul contents untouched, and although relief would be likely to occur I question whether a permanent cure would ensue. If, however, as in my sixth case, it be at once discovered that not only is there a constriction in the stomach, but also one at the pylorus, the question of gastro-enterostomy would be worth considering as it would lead to a considerable saving of time by substituting one operation for two. It has been performed by Tricomi successfully.

DILATATION OF THE STOMACH.

Though gastrectasis is by some authors only treated as a symptom it is one of such importance that in many cases it may truly be said to be a disease in itself; this is certainly the case in that serious and otherwise fatal form known as "acute dilatation." The capacity of the stomach cannot be taken as a guide in estimating the dilatation that should come under the notice of the surgeon, and, in fact, it is only in the well-marked cases that a surgical opinion is sought. Unfortunately, the aid of surgery is too frequently put off until extensive emaciation has ensued and the patient is almost moribund.

The causes of dilatation of the stomach are: 1. Mechanical obstruction at the pylorus or near it, or in the duodenum (a) from cicatrization of a simple ulcer at or near the pylorus; (b) from cancer of the pylorus; (c) from perigastritis leading to stricture or to kink of the pylorus; (d) from hypertrophy of the pylorus and spasm as a sequel of ulceration, which may continue long after the original ulcer has disappeared; (e) from fibroid thickening of the pylorus; (f) from polypus; (g) from congenital stenosis; and (h) from tumour outside the pylorus. 2. Dilatation from atony from various causes not mechanical, but persisting after the original cause has passed. 3. Acute dilatation from causes not yet understood.

Diagnosis.—Where there is severe dilatation the stomach soon becomes displaced downwards. This is associated with vomiting, the vomiting differing from that which occurs in any other condition. For instance, it does not occur after meals, nor even every day, but usually every second or third day and more frequently at night than in the day; and when the vomiting occurs it is, as a rule, in enormous quantity, the vomit consisting of fermented material with mucus, and sarcinae and yeast cells are usually present. When the dilatation is dependent on ulcer, the vomiting may be excessively acid, owing to the presence of hydrochloric acid. If, however, the dilatation is dependent on cancer, the acidity is due to lactic acid, and hydrochloric acid will be in small quantity or absent. Though patients with dilated

stomachs do not, as a rule, vomit after food, they complain of a sense of heaviness and discomfort, and have flatulent eructations, these symptoms becoming more and more intense as the stomach contents accumulate, until relief is obtained by vomiting. As a rule, the first sign noticed in stomach dilatation is the splash on succussion of the abdomen, this being the more marked the greater the contents. If the patient has previously vomited the stomach splash may be absent, but it is usually obtained by allowing him to drink freely of warm water. Constipation and diminished secretion of urine are nearly always present. Where the obstruction is mechanical visible peristalsis from left to right can frequently not only be felt but observed through the abdominal wall; and if visible peristalsis be present it is always indicative of considerable pyloric obstruction, which will probably only yield to surgical treatment. Loss of flesh, diminution of body temperature, coldness of the hands and feet, and general feebleness are characteristic of the later stages. Tetany is sometimes present, and if well marked may even lead to a fatal termination, but before this stage is reached, cramps in the muscles of the forearm and drawing inwards of the thumb, otherwise a tetanoid condition, are usually noticed. The amount of dilatation may be ascertained by distending the stomach with air introduced through a tube and pumped into it by means of a Higginson's syringe. This can be done with very little discomfort and without danger. A simpler method which I frequently employ is to give a dose of tartaric acid immediately after one of carbonate of soda, when if the patient is recumbent, inspection, palpation, and percussion show the increase in size of the organ.

Treatment.—The treatment in any form of gastrectasis will at first be medical and general, but if in a short time weight and strength be not definitely gained and maintained, with relief to pain and discomfort, then time should not be wasted by persisting with lavage and medical treatment for months until the vital powers have become sapped and the patient reduced to the last extremity of exhaustion before surgical treatment is advised.

Surgical Treatment.—The stomach should be washed out for a day or two before operation if the patient be not so far advanced that there will be danger in waiting, and during twelve or twenty-four hours rectal injections may with advantage supplement light stomach feeding. The last lavage should be several hours before operation. A subcutaneous injection of 10 minims of solution of strychnine may with advantage be given just before the operation if the patient be very weak, so as to forestall shock, which may also be further lessened by a pint of saline solution being given by the rectum and by operating on a heated operating table. After exposing the stomach by the incision previously described, a diagnosis of the cause will be speedily made by inspection and palpation of the stomach and pylorus. If there be stricture of the stomach itself, either from cicatrization or from ulcer leading to hour-glass contraction, it must be treated in one of the ways previously described. If the dilatation be dependent on adhesions of the pylorus and these can be detached leaving the pylorus free, they should be dealt with accordingly.

If there is a stricture of the pylorus it must be dealt with in one of the several ways to be immediately mentioned (pylorodiosis, pyloroplasty, gastro-enterostomy, or pylorotomy), according to its nature.

If the narrowing of the pylorus be due to spasm or hypertrophy of the circular muscular fibres, *pylorodiosis* or dilatation of the pylorus may be indicated. This is known as Loreta's operation. In the hands of many able surgeons this apparently simple operation has such a high rate of mortality as 40 per cent., and Loreta himself has confessed to having had several

deaths from hæmorrhage and peritonitis. Moreover, recurrence of the stricture seems to have occurred in so large a number of the cases that it is scarcely likely that the operation will hold its own in competition with the more exact and safer operations of pyloroplasty and gastro-enterostomy. It probably has some use in that very limited class of cases where the stenosis is simply dependent on spasm of the sphincter, which may either be caused by ulceration or independently of such a condition.

The principle of obtaining an increase of the calibre in a stricture by dividing the narrow passage longitudinally and closing the wound transversely is as ingenious as it is efficient, and in no situation can the procedure be of greater service than in simple stricture of the pylorus, when the operation is known as *pyloroplasty*, an operation which is destined to almost replace, if it has not already done so, *pylorodiosis*. The operation was performed first by Heineke in March, 1886, and his patient recovered. Mikulicz performed his first pyloroplasty in 1887, but the patient died; in his second operation in the same year the patient recovered. Of the first seventeen operations eleven recovered. If the pylorus be free from adhesions the operation is of the simplest, as the pylorus can be brought outside the abdomen and surrounded by gauze pads or sponges, so that this heavy mortality of 35.3 per cent. must have been due to an improper selection of cases, as later results only show a mortality of 9 per cent. in Czerny's clinic (Stendel), 7.6 per cent. in my own cases, and no mortality in several series. It is desirable to adopt all the usual precautions against shock, and the stomach should, if practicable, be washed out some little time before operation so as to avoid the danger of soiling the peritoneum. The incision through the pylorus must be longitudinal, commencing on the stomach side of the sphincter, and being prolonged through it either by scissors or by the knife over a director. Blunt hooks or catch forceps placed in the wound convert the horizontal incision into a transverse one, and it is then closed by a double line of sutures.

The modification of the operation by the use of an internal splint in the shape of a bone bobbin over which to apply the sutures is one that I have employed in all my operations and one which I consider offers several advantages. For instance, only two continuous sutures are required for the mucous and peritoneal margins respectively. The bone tube secures an immediate and thoroughly patent channel. It affords protection for from twenty-four to forty-eight hours to the line of sutures, by which time union should be established, and it prevents the new channel being inadvertently made too narrow. Although the bone bobbin that I originally invented for pylorotomy and enterectomy answers quite well, a recent modification in which the barrel of the bobbin is lengthened facilitates the operation.

Koepelin reports a modification of the operation known as *submucous pyloroplasty*. The horizontal wound along the pylorus is made through the two outer coats, serous and muscular, of the bowel and through the cicatrix, if there be one, and the exposed and unopened mucosa at once bulges like a hernia. The divided coats are then united vertically as in ordinary pyloroplasty. Three reported cases of the submucous operation have proved successful.

The advantage is, of course, in the avoidance of opening the stomach cavity, and therefore as lessening the danger of sepsis, the modification may be occasionally employed, but it should certainly never be performed in the presence of cancer. If, owing to the cicatrization of the ulcer, there be extensive hypertrophy of the pylorus with a large amount of thickening, pyloroplasty is insufficient, as in such cases con-

traction will be likely to recur. Here pylorotomy may be performed as in two cases of my own, or better still, gastro-enterostomy, which is a simpler, quicker, and safer operation. Numerous and firm adhesions, active ulceration, and the presence of new growth, are also contra-indications for pyloroplasty.

Dr. Maurice Richardson (a) advocates partial excision of the stricture where there is extensive thickening and well marked stricture. This pyloroplasty with partial excision seems to be the right practice in bad organic stricture. The dense tissue being cut away, the lozenge-shaped incision can be readily sutured so as to become transverse, whilst if a simple longitudinal incision is made through the tissues of a dense stricture it is impossible to convert it safely into a transverse line of sutured wound owing to the great tension if the two ends be made to meet in the middle. If on opening the stomach or pylorus a polypus be found as a cause of the obstruction it must be removed, and, if necessary, the operation can be completed by a pyloroplasty as in a case of my own mentioned under the head of tumours.

If the dilatation be dependent on an obstruction outside the stomach—as, for instance, a tumour of the pancreas, liver, or gall-bladder—relief may be given by removing the tumour, or, if that be impracticable, by *gastro-enterostomy*.

If cancer of the pylorus be found to be causing the dilatation *pylorotomy* may be indicated if the disease be limited and there be no secondary infection, but if it be too extensive *gastro-enterostomy* will be the only treatment likely to afford relief.

CONGENITAL STENOSIS OF THE PYLORUS.

Maier (in Virchow's Archives) holds that a degree of congenital stenosis is a frequent, if not the most frequent, though unrecognised, cause of dilatation, and he cites a number of cases, mostly in adults, of chronic catarrh of the stomach with dilatation in which stenosis of the pylorus varying from three millimetres to one centimetre (the normal, one to three centimetres) was found. He is careful to distinguish between the congenital form and that due to catarrh, ulcer, and cancer, the acquired forms of stenosis, and gives his reasons for considering the stenosis primary and the catarrh secondary in the cases mentioned. He acknowledges, however, that clinically the distinction is extremely difficult. Basing his classification on the anatomical structure of the pylorus he distinguishes between a simple form of stenosis in which there is a round or slit-like narrowing of the pyloric orifice and a complicated form due to a hypertrophy of the longitudinal or of the circular fibres of the pyloric region. In the first case, where the longitudinal fibres are hypertrophied, the stenosis is usually conical in shape, with the apex of the cone at the pylorus and projecting into the duodenum after the manner of the os uteri into the vagina, but sometimes it is ring-like, the constriction then measuring as low as from four millimetres to five millimetres. When the circular fibres, on the other hand, are increased the form taken is usually that of a thick swelling, the lumen of the canal not being so much reduced as in the former case.

The interest of a case related very fully by Dr. W. K. Penn with an account of the necropsy by Dr. Maxwell Adams, lies in its proving conclusively that congenital stenosis does occur in a form capable of relief by operation. To judge from the literature of the subject, this condition is not of frequent occurrence, but it may be more common than supposed, as necropsies are not frequently made in the case of children dying out of hospital, and persistent vomiting in infants is not a very uncommon event.

CLIMATIC OBSERVATIONS AT ST. ANN'S HILL.

By ARTHUR G. BENNETT,
Resident Physician, St. Ann's Hill.

THE observations on which this article is based were taken at St. Ann's Hill, a distance of about one mile and a half from the well-known and historical village of Blarney.

The diagrams and tables which I have been at some pains to prepare in themselves afford sufficient information as to the conditions prevailing locally during the past year, but as these scarcely admit of embodiment in this contribution, I propose to make a few remarks on points which are likely to be of general interest.

In the first instance, the point that strikes one on looking through the records for January, is the fact that on seventeen nights only has the minimum temperature been at 32 degs. F. or below. The lowest point actually reached being 23 degs. F. on January 23rd, while the highest temperature for the month was recorded on January 15th, when the mercury touched 53 degs. F. The mean minimum temperature was somewhat above freezing point while the mean maximum was over 45 degs. F., not a bad record for the coldest month of the year. The figures plainly show that the mildness of the winter climate of St. Ann's Hill has not been exaggerated.

In connection with the barometer it is interesting to observe that in spite of the fact that over 5½ ins. of rain fell during the month the mercury never fell below 29 ins.; the mean of 29.6 ins. cannot fairly be described as a low one, and although the rainfall was undoubtedly heavy, on only two occasions did it exceed 4 ins. in the 24 hours. From this it follows that if the rainfall was not severe at any one time it must at least have been persistent, and such was the case, for out of 23 rainy days 22 consecutively were wet.

It is interesting to observe the rise which occurs from January to February, especially in the mean minimum temperature, which is higher than that for March, though the mean temperature for that month is proportionally higher than for February.

Though the mean barometrical pressure for February was as high as that for January it is worth noting that the lowest reading but one for the year occurred during that month as well as the highest, viz., 28.8 ins. on February 12th, and 30.68 ins. on the 28th.

In the first half of the month the barometer was low, and the rainfall high, while at the end the reverse of these conditions obtained, with the result that with a high rainfall a not unfavourable mean barometrical pressure was recorded.

The records for the month of March show little of interest to comment upon except that it was one of the driest months of the year, in fact out of a total of 42.45 ins. for the twelve months only 20.49 ins. of rain fell during the nine months from March 1st to November 30th, leaving 21.96 ins. to be accounted for in the months of January, February, and December. However, December dashed in with a grand total of 11.68 ins. to its credit, thus placing the rainfall for the year well above the normal level. On four days in December over an inch of rain fell in twenty-four hours, the record for the year being 2.45 ins. on December 13th. It was only to be expected that with such a rainy month the barometer would reach a low point, and such was indeed the case, for on December 28th the barometer registered the lowest point reached for the year, viz., 28.3 ins., and with this fall there was considerable increase in the force of the wind.

So that although there was a drought during the summer months, in which the rivers in the neighbourhood were almost completely dried up, and the fish in them were dying for want of water, the rainfall on the whole was in excess of the average.

But the point which to me appears the most striking is that although the winter months were undoubtedly mild, there was no extraordinary degree of heat recorded during the summer, in point of fact one feels tempted to assert that the idea of a place being excessively hot in the summer because of the mildness of its winter climate is an erroneous one. I was surprised on two or three occasions by visitors to St. Ann's Hill during the summer months, observing that the place was a good deal cooler than at the seaside.

I account for this by the supposition that the reflected light from the ocean would create a greater glare and heat than the direct sunlight shining on the meadows and trees by which this resort is surrounded.

In spite, therefore, of the excessive rainfall for the year, of which more than half was due to three months of exceptionally heavy rain, the absence of sudden changes in the atmospheric conditions accounts for the uniformity of the barometrical readings, and makes it impossible to regard the climate of the neighbourhood as anything else than salubrious or in other words conducive to bodily health and vigour.

Clinical Records.

TWO CASES OF

LAPARO-PYLEPHLEB-ANASTOMOSIS. (a)

By Mr. R. J. PYE-SMITH.

THIS operation was introduced by Dr. Drummond and Mr. Rutherford Morrison in 1894.

CASE I.—A girl, æt. 18, had been under the care of Dr. Burgess at the Sheffield Royal Hospital, with enlarged liver and spleen and ascites, for three years. She had been tapped frequently, and as the abdomen refilled in a month, Dr. Burgess requested Mr. Pye-Smith to operate. At the operation on November 10th, 1899, the capsule of the liver was found to be thick, and the spleen greatly enlarged. The liver, spleen and omentum were attached to the anterior abdominal parietes. During the four months that had elapsed since the operation a considerable quantity of fluid had gradually accumulated, but the improvement in this and other respects had been very great.

CASE II.—A man, æt. 31, was admitted to the Sheffield Royal Hospital, under the care of Dr. Burgess, in September, 1899, for hæmatemesis. Whilst in the hospital, slight ascites developed, but subsided under medicinal treatment. There was an alcoholic history, and Dr. Burgess diagnosed cirrhosis and asked Mr. Pye-Smith to operate. At the operation on January 16th, 1900, a hob-nailed condition of liver was found with an enlarged spleen, but no ascites. The left lobe of the liver was attached to the anterior parietes and the omentum fixed along the edge of the wound. The patient was now, two months after the operation, in a comfortable condition. It is, of course, too early to judge of ultimate results in either of these cases.

TIBIAL OSTEO-SARCOMA MISTAKEN FOR A SLIPPING CARTILAGE. (b)

By Dr. GIBNEY,
of New York.

I AM enabled to show a specimen derived from an amputation at the lower part of the thigh. The patient, a woman, æt. 26, when walking down a hill in July, 1898, had inadvertently turned her foot outward, with resulting

(a) Patients shown at the Sheffield Medico-Chirurgical Society, March 15th, 1900.

(b) Specimen shown before New York Association of Medicine, February 9th, 1900.

very acute pain, lasting fifteen to twenty minutes, over the internal semi-lunar cartilage knee, and inability to straighten the limb for several minutes. Disability in bed for two or three days was followed by persistent weakness and more or less pain in the limb. Several recurrences of this "giving way" of the limb, with increase of disability, had led to the application of plaster of Paris bandages in the Fall.

In the spring of 1899, when the patient was seen for the first time, she was soon enabled to walk much better by the application, on April 6th, 1899, of a brace which was adjusted at first to permit, and afterwards to prevent, motion at the knee. Pain and tenderness were combated by sinapisms and the cautery. Removing the brace without permission, she fell with another painful "giving way" of the limb. She left the city June 20th, 1899, carefully instructed in the management of the brace. Pain and disability persisted, however, and increased during her prolonged absence, and when she was again examined on January 29th, 1900, considerable enlargement was found over the head of the tibia with no distension of the synovial sac. Up to that date the trouble was believed to depend on laceration of the internal semi-lunar cartilage with a wrenching of its attachments, the prominent features of the case having been repeated sudden arrest of locomotion from slight injury in which the foot was twisted, pain at the internal tibial tuberosity, later a thigh and calf measuring $1\frac{1}{2}$ ins. and $\frac{1}{2}$ in. less in circumference than those of the unaffected limb, considerable reflex spasm, absence of heat, a freely movable patella and diminution of pain and increase of ability following the application of a brace. On February 25th, 1900, when the healing of the surface which had been blistered permitted a better examination, a small and painful indurated mass was discovered, which was incised on February 10th and found to be an irregular whitish tumour over the tuberosity of the tibia and encroaching on the joint. The underlying bone was softened. A second tumour of greyish material, with hæmorrhagic spots, was found near the first, and to the outer side of the tibia. The examiner reported round-celled sarcoma with some spindle cells, and even giant cells, and amputation was done on February 15th about 3 ins. above the condyles.

Transactions of Societies.

ROYAL ACADEMY OF MEDICINE IN IRELAND. SECTION OF PATHOLOGY.

MEETING HELD FRIDAY, FEBRUARY 23RD, 1900.

The President, Dr. A. C. O'SULLIVAN, in the Chair.

NOTE ON THE EFFECT OF CERTAIN VARIETIES OF THE NUTRIENT MEDIUM ON THE GROWTH OF THE TYPHOID BACILLUS.

THE SECRETARY (Professor E. E. J. McWeeney, M.D.) stated that the results of a series of experimental cultures made by him, and exhibited last meeting, went to show that (a) the growth improved with increasing addition of $\frac{N}{10}$ NaO H to the unneutralised gelatine up to the beginning of alkalinity (indicator phenolphthalein); (b) the addition of salt, in quantities varying from 0.1 to 1 per cent., to the fully neutralised gelatine (same indicator) made no difference in the amount of growth; (c) the omission of both salt and peptone exercised no appreciably unfavourable influence on the growth in gelatine made with meat decoction; (d) addition of quantities of phenol to gelatine in the proportion of .05 and .5 per cent. exercised an inhibitory influence on all growths when the addition exceeded .07 per cent.; between .05 and .07 the effect was to check the anaerobic growth; and (e) Parietti's solution added to ordinary bouillon suppressed the growth of typhoid, when coli was also present. The addition of 9 drops (0.3 c.c.) to 10 c.c. bouillon, to which was subsequently added a few drops of a mixture containing both typhoid and coli (e.g.,

bile from a patient dead of typhoid), caused such retardation of the growths produced by plating out the tube on gelatine as to make them closely resemble true typhoid colonies. Tests, however, proved that nothing but coli grew in the Parietti's tube, although ordinary agar plates from the same material yielded an abundance of typhoid colonies. It was on the suppression of typhoid by the Parietti test that the speaker desired to lay special stress.

THE PRESIDENT (Dr. A. C. O'Sullivan) said it would be interesting to know if a further condition of alkalinity would make the growth go off, or possibly make a stronger growth. The observation that phenol acted first on the anaerobic growths might be explained by the fact that typhoid bacilli are what are called facultative anaerobes—that is, their natural mode of growth is aerobic, and their anaerobic growth is, therefore, strained, and the inhibitory drug acts first on the re-trained kind of growth. The method of Parietti was very useful for the analysis of water, but was entirely useless for analysing milk for the typhoid bacillus, because there were so many organisms in milk, standing a mixture of hydrochloric acid and carbolic acid better than the typhoid bacillus.

Dr. E. J. McWEENEY, in reply, said he agreed with the statement that Parietti's solution was of no use for the analysis of milk. On plating out with gelatine they got a number of things which they could not say definitely to be true coli or pseudo-coli.

HISTOLOGY OF TUBERCULOSIS OF INTESTINES AND LIVER.

THE SECRETARY (Professor McWeeney) showed naked-eye and microscopical preparations of this condition taken from a patient in Dr. Dempsey's ward at the Mater Misericordiae Hospital, who had died of diarrhoea due to tuberculous enteritis. The floor of the very extensive ulcers was composed of granulation tissue consisting of cells with simple and polymorphous nuclei, but seemingly devoid of giant cells. Enormous multitudes of tubercle bacilli were lying between these cells, and were often actually in contact with, but not within, them; yet the tissue showed practically no sign of caseation—a remarkable fact in view of the extensive areas of caseation met with so commonly in tuberculous lymphatic glands, where even the most careful examination fails to reveal a single bacillus. As the result of a very careful examination of a number of sections of tuberculous liver, he had arrived at the conclusion that many of the tubercles began by proliferation of the nuclei of intra-lobular capillary endothelium. The products of such proliferation were the "epithelioid" cells, with which a certain number of un-nucleated "lymphoid" elements were *ab initio* associated. He had arrived at the conclusion that the hepatic cells immediately adjoining the tubercle underwent metaplasia, and became converted into "epithelioid" elements. The giant cells began to make their appearance when the tubercle attained a diameter of 0.2 mm.; between 0.1 and 0.2 mm. giant cells were absent. He had convinced himself that in this case at least the multiplication of nuclei took place either by direct division or by a sort of sprouting. He had failed to observe mitoses in young giant cells.

CORNEAL DERMOID TUMOUR OR PATCH.

Mr. ARTHUR BENSON and Dr. H. C. EARL described and showed sections of a dermoid tumour removed from the globe of a child, aged four years. The growth straddled the cornea-scleral junction, but extended more on the cornea than on the sclerotic, and occupied the whole thickness of the cornea. It was only slightly raised above the surrounding tissues, and was of a creamy-white colour, and slightly rough, or rather unpolished on the surface. It grew, contrary to the usual custom, at the inferior nasal side, and extended almost to the corneal apex.

Dr. WALTER BROWN, Belfast, recalled a similar case about four months ago, in which the wound filled up with granulation tissue, which he had great trouble in treating, the only thing keeping the tissue in subjection being nitrate of silver.

Dr. BENSON, in reply, said it took about two weeks to heal up, and the resulting cicatrix was a perfectly smooth leucoma such as they would have after an ulcer.

THE SCOPE OF X-RAYS IN DENTAL PATHOLOGY.

Mr. GEORGE J. GOLDIE, in a communication on the above subject, demonstrated the extreme usefulness of the X-rays in 1. Fracture and dislocation of teeth in the jaw. 2. Fracture of the jaw itself. 3. The diagnosis of inflammation round the roots of teeth; alveolar abscess. 4. The diagnosis of inflammation round the roots of teeth, giving rise to symptoms remote from the seat of lesion—neuralgia, trismus, &c. 5. The treatment of impacted and in-coming wisdom teeth. 6. The normal eruption of the permanent teeth following the temporary or milk teeth. 7. The abnormal eruption of the same. 8. The absence or presence of any missing tooth in the jaw when its eruption has been abnormally delayed. 9. The regulation of teeth malposed in the jaw. 10. Many purely clinical dental conditions which could only be mentioned without being described. 11. Exostosis of roots of teeth. 12. Foreign bodies in the antrum of Highmore. He illustrated each of the conditions by lantern slides of X-ray photographs taken from cases from practice of which, during nearly four years, he had done over 300. His conclusions were that in dental practice was afforded by X-rays a means (α) corroborating or disproving existing diagnosis; (β) of establishing a diagnosis where that had not otherwise been found possible; and (γ) of demonstrating these to the patient. The credit of having used X-rays in dental pathology was due, at all events, in Ireland, to Dr. Richard Theodore Stack.

Mr. WILLIAM S. HAUGHTON remarked that the new mode of examination seemed likely to bring many advantages both to operator and patient. He described in detail how certain technical difficulties had been overcome by the use of "cut celluloid" photographic films, enclosed in orange and black paper bags, which were again enclosed in an india-rubber bag specially manufactured to his order, as most samples of rubber contained so much sulphur in their composition as to render them very opaque to X rays. In general terms, young teeth required shorter exposures than in adults; the contrast between the shadow of tooth and alveolus was more marked in young mouths; and in adult life and old age the density of the angle of the lower jaw approximated to that of the wisdom tooth. [A practical demonstration of the process was given during the course of the meeting, in which Mr. Haughton skiagraphed an unerupted canine tooth in a patient, *æt.* 20. The skiagram was taken, developed, and projected as a lantern slide, the whole process occupying just half an hour.]

SPONTANEOUS RUPTURE OF THE OESOPHAGUS.

The SECRETARY (Professor McWeeney) exhibited a specimen of this rare condition. Patient, an alcoholic male, *æt.* 40, had retched violently before going to work. His face and neck became swollen and his breathing difficult, so that he was forced to go to the Mater Hospital, where he died a few hours after admission. At the autopsy there was enormous swelling of the face and neck, due to subcutaneous emphysema. The origin of this was traced into the posterior mediastinum, the contents of which were coated with grey pultaceous matter, which could be seen escaping through a longitudinal rent half-an-inch long in the anterior surface of the oesophagus just above the diaphragm. The immediate cause of death was intense oedema of both lungs, associated with failure of a fatty right heart.

CYCLOPIAN FŒTUS, WITH SUPERNUMERARY FINGERS AND DIAPHRAGMATIC HERNIA.

Dr. H. C. EARL exhibited a specimen of above. There is a large encephalocele in the frontal region. It contains the forebrain, which is undivided, only showing a slight groove at its posterior extremity. The surface shows no convolutions. Behind, and partly covered by the forebrain, is a mass of tissue which appears to represent the optic thalami. From this the optic tracts arise, and form the optic commissure, from which a single optic nerve comes off. There is a single eye lying in the middle line; the olfactory lobes are absent; the frontal ethmoid and nasal bones are absent, as are the vomer and nasal septum; the nose and the nasal passages are absent; each hand has an additional digit on the ulnar side; that on the left side has two

phalanges and a nail, that on the right side is a rounded mass about the size of a pea, attached by a narrow pedicle to the little finger; it has no nail. There is a large opening in the diaphragm on the left side, through which the greater part of the abdominal viscera project into the thorax. The heart, lungs, and thymus gland lie on the right side of the thorax. The left side of the thorax contains a part of the left lobe of the liver, the spleen, the greater part of the stomach, the cæcum, and the greater part of the small and large intestines.

FŒTUS WITH HERNIA FUNICULI UMBILICALIS.

Dr. H. C. EARL said the hernia is globular in shape, and ten-and-a-half inches in its greatest circumference. It contains the whole liver and a considerable part of the intestine. The umbilical cord is attached to the left side of the tumour.

The Section then adjourned.

SHEFFIELD MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD THURSDAY, MARCH 15TH, 1900.

Dr. BURGESS, the President, in the Chair.

Dr. HALE showed:—1. A case of congenital syphilis. 2. Lichen syphiliticus. 3. Tuberculous syphilide: imulating lupus, and read notes of a case of iodide of potassium eruption.

Mr. W. DALE JAMES showed:—1. A case of pityriasis rubra-pilaris in a man of 30. It began when he was 8 years old upon his right shin, which is the only patch he has. He has been reported frequently, having four years ago been under Dr. Payne, at St. Thomas's. The mortar-like accumulation, and the presence of plugs in the follicular openings were very highly diagnostic. 2. A beautifully developed tertiary macular syphilide.

Mr. SNELL introduced the following patients:—1. A youth, *æt.* about 20, with a large solitary tubercle of iris (left eye). The lungs were free from disease, but there was thickening of the left epididymis. 2. A boy with ectropion treated with Thiersch graft. 3. Two cases of symblepharon treated with Thiersch grafts. 4. A man with a piece of steel embedded in the retina. 5. A child with palsy of both external recti, after diphtheria. 6. A woman with very marked periarteritis of the central retinal artery.

Mr. SNELL also exhibited (a) a water-colour drawing of a congenital papilloma of the conjunctiva which was sufficiently long to protrude through the palpebral fissure, and to rest on the lower eyelid; (b) a series of stereoscopic photos, including among them three instances of rodent ulcer, microscopical sections of which were also at the same time shown; (c) embolism of a branch of the central artery of the retina, perimeter charts of four cases.

Mr. SNELL also showed a beautiful work, which was illustrated by photographs from large water colour drawings of forest and other rural scenery, done by a patient who had several years since undergone cataract extraction at his hands. The same gentleman had, since the operation, been a successful exhibitor at the Royal Academy.

Mr. PYE-SMITH showed two cases of Laparo-Pylephleb-Anastomosis, which will be found under the head of "Clinical Records."

Dr. SINCLAIR WHITE showed: (1) unusual gall-stones; (2) a boy on whom Estlander's operation had been done five years previously. The lung on the affected side had regained almost its normal size, and there was no lateral curvature of the spine and very little deformity. (3) A rapidly-growing sarcoma of the scapula in a man, which was subsequently dealt with by total excision of the scapula; (4) a woman with early cancer of the left breast, the right mamma having been removed for cancer six months previously. There was no evidence of cancer elsewhere.

Dr. STANLEY RISELEY showed a man, *æt.* 44, who seven years ago was struck on inner side of right cornea by a piece of coal. He said that three years afterwards a growth appeared in the same situation, and that eighteen months subsequently part of the growth was removed. He came under Dr. Riseley's care four months ago with

a growth firmly attached to the cornea and conjunctiva, which, on microscopic examination, proved to be an epithelioma. There are apparently no glands involved. The growth has rapidly increased in size. The patient will not consent to operation.

LIVERPOOL MEDICAL INSTITUTION. MEETING HELD THURSDAY, MARCH 8th, 1900.

MR. EDGAR BROWNE, F.R.C.S.E., President, in the Chair.

CASES.

DR. WM. CARTER related (1) a case of acute Bright's disease, characterised by the urine containing three-fourths albumen, epithelial, and hyaline casts, and oedema yielding entirely to the exclusive use of milk as a diet, complete rest, and a diaphoretic mixture after a few months. Dr. Carter deprecated the indication there seemed to be in some influential quarters to depart from the simple and safe principles of treatment hitherto applied in such cases. (2) A case of so-called pernicious anæmia in a man æt. 44, successfully treated. The red corpuscles had fallen to 380,300 per cub. m. and hæmoglobin to 30 c.c. There was oedema, febrile attacks, prostration, anæmia, and constant vomiting. The treatment employed was rest in bed, liq. hydrarg. perchlor. $\text{m} \cdot \text{j}$, ferri perchlor. $\text{m} \cdot \text{j}$, aqua 5j every hour for eight hours daily by the mouth, 5ij of sanguis bovinus exsic, diffused through 5iv of water injected into the bowel twice daily, and afterwards residuum rubrum and St. Raphael's wine. The last estimation showed the corpuscles to be 4,080,000.

MR. W. THELWALL THOMAS read a "Note on supra-pubic lithotomy in old men with enlarged prostate." In such cases the prostatic enlargement sometimes increases the perineal depth to such a degree that neither forceps nor finger can reach the stone in perineal lithotomy; and in all cases the supra-pubic operation is preferable and safer, with modern precautions, and carried out as suggested. Before operation, render the urine and urinary tract as sterile as possible. Give urotropine 5-10 grs., t.d.s., for a few days to sterilise the urine; if cystitis is present, wash out the bladder twice a day, or more frequently, with chinosol 1-1200; wash and cleanse the glans penis, and urethra with chinosol lotion; boil the catheter, and as a lubricant use a mixture of soft soap and glycerine, 8-4, with biniodide of mercury, 1-1000. Operation: The bladder is emptied by a catheter and washed, an incision made in the middle line, 3-4 in. long, the wound deepened until the extra-peritoneal fat is reached just above the pubes, when air is pumped into the bladder until it rises like a balloon into the wound, pushing the peritoneum upwards. Two silk loops are passed through the muscular coat of the bladder by means of a handled needle, the origin of one rectus muscle being nicked to make room if necessary. An assistant holds the loops, thus keeping the bladder well up; an incision is made into the bladder and the air escapes; the finger is passed into the bladder, the calculus felt and extracted. The bladder wound is sutured, continuous chromicised gut in the mucous membrane, and continuous silk, *a la* Lembert for the muscular coat, the bladder suture tested by air distension, the loops are removed. A small incision is made through the skin to one side of the middle line to accommodate a glass tube passed down to the sutures in the bladder wall. The original skin incision is sutured, and a gauze dressing under a double spica bandage applied. A soft catheter is tied into the bladder, which is washed out daily with two ounces of chinosol lotion, and catheter removed in a few days. Four cases had been operated upon in patients, æt. 61, 63, 70, 80; all had recovered and were well—three, one year since operation. The calculi removed, two uric acid uncoated with phosphate, fifteen in one case, total weight 140 grs.; six in the other, weight 133 grs.; two uric acid coated with phosphate, 46 and 123 grs. respectively.

MR. F. C. LARKIN considered supra-pubic lithotomy satisfactory in these cases, and made it a practice when operating upon such cases, at the same time to remove

the obstructing piece of prostate, with punch forceps. When the condition of the bladder was bad he preferred to employ supra-pubic drainage for some days.

Messrs. Raw, Damer Harrison, and Newbolt also spoke.

BUBONIC PLAGUE.

DR. A. S. GRUNBAUM read a paper on "Bubonic Plague," describing the history, ætiology, the plague bacillus, experiments on animals, distribution, clinical forms and symptoms, diagnosis, prognosis, prevention, inoculation, quarantine and sanitary measures, treatment, ancient and modern.

DR. BALFOUR STEWART alluded to the nature of Haffkine's prophylactic. He said that Haffkine, partly on theoretical and partly from observations of the results of anti-cholera inoculations, decided to retain the supernatant broth of the plague culture in his prophylactic. In the anti-cholera inoculations only the bodies of the microbes were injected, and it was noticed that, although the case incidence was lowered, yet if the disease was contracted there was no marked advantage to the inoculated over the uninoculated. Haffkine thought that if the supernatant broth containing the toxins formed by the microbes were injected along with the microbes the system would become immune to the toxins if the disease were contracted. His own experiments on animals tended to confirm this hypothesis.

DR. HOPE referred to the methods adopted in the port of Liverpool for the medical inspection of vessels coming from plague infected ports or having suspected cases on board. He considered that the great damage to commerce as a result of the importation of plague into the city was a powerful incentive to shipowners and to the Mersey Dock Board to co-operate with the Port Sanitary and Customs' officers. When the wide diffusion of plague in places remote from one another was considered, it was a remarkable thing that no plague had been introduced into this country.

DR. N. E. ROBERTS regretted that a method of serum diagnosis was not practicable for plague, and thought that if plague appeared in this country it would be by mild ambulant cases. In an extensive experience of diphtheria, he was convinced that the spread of the disease was due to the mild unrecognisable forms found in children attending schools, and so he, in his duties in port work, was ever anxious lest "ambulant plague" might slip through; yet Dr. Stewart's statement that ambulant plague was not certainly infectious would tend to allay his fears.

DR. A. C. RENDLE spoke in favour of quarantine as opposed to inoculation, and mentioned some of the methods adopted by the Madras Government, also the successful extermination of plague in Penang. Inoculation was not altogether free from grave risks, as shown by a temperature chart of a severe case of pleurisy following inoculation. The facility of diagnosing plague by staining the blood was alluded to.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

AN Ordinary Meeting of the Society was held in the Library of the Medical School, Thoresby Place, Leeds, on Monday, March 19th, the President, Dr. J. B. HELLIER, in the Chair.

This meeting was devoted to a discussion on the Treatment of Fibro-Myoma of the Uterus. The special points selected for discussion were (a) choice of operative route; (b) myomectomy; (c) total versus supra-vaginal hysterectomy; (d) the treatment of the appendages; (e) details of technique; (f) drainage; (g) after results of operations.

A large number of specimens and drawings were exhibited by Drs. Stanmore Bishop, Briggs, and the President.

DR. T. B. GRIMSDALE (Liverpool) in opening the discussion, referred to the recent paper of Dr. Champneys on the natural and operative mortality of fibroids, and considered that though the figures quoted by him were misleading in some respects, still the mortality of

fibroids left to themselves was low, and it behoved us to be watchful that our methods of treatment do not become more dangerous than the disease. The indications for operative interference may be divided into relative and absolute. The relative indications comprise all the various well-known symptoms of these tumours, including the mere presence of a tumour. The absolute indications cover all the possible accidents which may happen calling for immediate operation. Of these Dr. Grimsdale has met with tumours obstructing delivery, torsion of the pedicle of a subperitoneal tumour causing acute peritonitis; suppurating fibroid tumours, which may result sometimes from thrombosis of the vessels supplying them, and ascites from chronic peritonitis, especially in calcifying tumours. The relative indications may be divided into vaginal and abdominal. Among these we may have (1) rapid growth of the tumour due sometimes to cystic degeneration, (2) pain due to pressure and often to accompanying disease of the appendages, (3) size and weight incapacitating a patient, (4) pressure symptoms, especially on bladder, rectum, or ureters, (5) severe hæmorrhage, (6) foetid vaginal discharge which usually indicates a tumour protruding into the vagina. *Choice of Route.*—Generally speaking vaginal symptoms require vaginal route, abdominal symptoms indicate the selection of the abdominal route. The combined method, Dr. Grimsdale considered, was often a confession of failure to complete the operation undertaken in the first place. In the choice of route various questions must be considered. The mortality after either abdominal or vaginal operation was mainly due to sepsis, and experience has seemed to show that it is easier to avoid infection from without by operating *per vaginam*, but now the results of abdominal operation are so good that it may be considered as safe as the vaginal route. The avoidance of hernia and absence of a scar in vaginal operations are not factors of great importance in deciding upon the route. Against the vaginal route we have (1) difficulty of diagnosis in some cases, (2) tedious operation, (3) myomectomy can rarely be carried out efficiently. Dr. Grimsdale prefers the method of Baer for abdominal hysterectomy, and does not use any drain. Myomectomy, which can be performed either per the mucosa of the uterus or through the peritoneum, has enormous possibilities of usefulness. In conclusion, Dr. Grimsdale referred to the value of oophorectomy and ligation of the uterine arteries in certain cases.

Mr. E. S. BISHOP considered that the combined method of operation was of great value in certain cases, and might be adopted as a method of choice. It was easy to separate the vaginal mucosa and ligature the uterine arteries from below, and then make the abdominal section. Removal from above was then a much simpler proceeding. He attached great importance to careful suturing of the peritoneal surfaces to avoid any possibility of a coil of bowel becoming adherent and to avoidance of drainage after the operation.

Dr. H. BAIGGS (Liverpool) exhibited a series of water-colour drawings selected from 133 cases of uterine fibroids treated by him. By the vaginal route he had operated on forty-five cases with uniform success. By the abdominal route the mortality had only exceeded 5 per cent. in old standing broad ligament tumours placed deeply in the pelvis, and often very adherent. Errors in diagnosis also (dermoids, ovarian tumours, &c.) occur and increase much the sufferings of patients by operations often being delayed far too long.

Dr. BRAITHWAITS (Leeds) pointed out that most operations for fibroids were mutilating procedures, and strongly recommended an extension of myomectomy in these cases.

Dr. A. DONALD (Manchester) referred to the bad effects of long-continued hæmorrhage on the heart muscle, which often indirectly led to fatal termination in fibroid tumours. In some cases he had operated on account of marked œdema of the lower limbs due to pressure. He thought a sepsis was of more importance than the choice of method of operation. He considered that in certain cases oophorectomy, which was distinctly safer than abdominal hysterectomy gave excellent results.

Dr. T. E. GEMMELL (Liverpool) endeavoured whenever possible to perform myomectomy.

Dr. LLOYD ROBERTS considered that in young women myomectomy should always be performed, if possible. Frequently, however, complete removal would be required, and he believed the abdominal method was preferable in the great majority of cases. The "combined" method certainly shortened the duration of the operation, and allowed for good drainage per vaginam. Broad ligament tumours were extremely formidable to remove, in many instances the ureters were in great danger of injury.

Dr. ARNOLD LEA referred to the similarity between the thick walled broad ligament cysts and inter-ligamentous fibroids. In any doubtful cases abdominal section should be performed. He also showed a modification of the corkscrew tenaculum and a curved knife which were of value in vaginal enucleation of fibroids.

The PRESIDENT showed a uterus removed by panhysterectomy illustrating some of the points under discussion. He strongly advocated vaginal drainage after these operations since there was often a considerable amount of effusion into the pelvis.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, March 31st, 1900.

MORTALITY AND DISINFECTION.

At the last meeting of the Académie de Médecine, M. Vallin suggested that transmissible maladies could be treated by isolation, disinfection, and vaccination as the most powerful means of prophylaxis. In the last séance a member declared that unless for diphtheria it was impossible to pronounce on the utility of disinfection in the number of contagious diseases, and especially in the case of measles, and said it was only against the complications of that malady that measures of disinfection were justified. In concluding, however, he asked the Academy to inscribe pneumonia and broncho-pneumonia on the list of maladies of which the notification was obligatory. M. Vallin thought that, in the interest of science that obligation should be reserved for those affections presenting an epidemic or infectious character; in a word, where the virulence of the pneumococcus was intense.

ACTINOMYCOSIS.

M. Poncet spoke at considerably length on actinomycosis in man and said that within the last two years numerous researches had been made on the question and especially on the biology of the parasite and the lesions it provoked. Having been able to classify all the cases published in France since 1898, he was in a position to make a few observations on the special characters of the malady and say a word on the treatment. He wished at first to call attention to the fact that it was not necessary to wait for the appearance of the characteristic yellow grains to arrive at the diagnosis of actinomycosis. Clinical examination alone, permitted the affection to be recognised, thanks to the following symptoms:—hybrid aspect of the lesions with torpid evolution of the same with cicatrization of old fistulae in the immediate neighbourhood of recent invasion. On the face and neck in particular diffused and ordinarily very painful thickening of the ligament and trismus as soon as the muscles were attacked, and the absence of any swelling of the ganglions, in spite of the existence of several ulcerated tracts, appeared to him to be characteristic of actinomycosis. He had collected twenty-six new cases, of which twenty-one were in the cervico-facial region, one in the

pleural region with perirenal infiltration, two in the cæcal and prececal regions, one in the umbilical region and one near the anus. The inoculation—habitually due to ears of wheat or to the débris of cereals—seemed to have entered almost always through the digestive tract. The evolution of the malady was constantly subacute or chronic of from three months to six years with successive inflammatory attacks producing abscesses in series. As to the treatment, surgical intervention seemed to him to be indispensable. The operation might consist simply in an incision followed or not by curettage and cauterisation of the walls of the abscess. Iodide of potassium should be always given internally, which he considered, however, only in the light of an adjuvant to the surgical treatment, and that in spite of the favourable results obtained by certain authors; he would say as much of essence of eucalyptus, which recently was successful in the hands of Butler.

CHOREA.

Dr. Garaud, of St. Etienne, has published three interesting cases of chorea treated successfully by rectal injection of a solution of cacodylate of soda. During the first five days of the treatment the children were given a daily injection of one drachm of the solution (cacodylate of soda grs., $\times$ water 3vj.), the following five days two injections daily and the third period of five days, three injections. The patients were allowed to rest for five days more when the treatment was resumed as before for another series of five days. The cure was complete at the end of a month from the time the treatment was begun. In none of the cases was any intolerance observed, and analysis of the urine revealed no traces of albumin.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, March 31st, 1900.

At the Free Society of Surgeons Hr. Rose read a paper on

RECOVERY FROM THE IMBECILITY OF EPILEPSY.

After a short retrospect on the changes that had taken place in the indication for trephining during the century, he showed a boy who had developed normally up to his fourth year, and who in September, 1898, ran with his head against the corner of a door. The boy's mother suffered from epilepsy. A superficial wound was caused by the blow; but this healed up, and nothing more was thought about it. A fortnight later fits came on, which became frequent. At the same time the child's manner completely changed. He became apathetic, restless, and stupid. When admitted into the Bethanien Hospital he lay in bed with his hips drawn up, he constantly dirtied and messed himself, spoke not a word, and ate and drank greedily, and had frequent fits. After passing through an attack of measles it was decided in December, 1898, to trephine, under the assumption that the speech centre was affected by the injury to the head. A skin-periosteum and bone flap was raised from the forehead. The dura appeared normal, and also the underlying brain when this was cut through. Puncture of the brain with an aspirating needle gave no result. The flap was replaced, but in one corner a small opening remained. The child's condition was not much changed by the operation, which was well borne,

the mental condition was unchanged at first, and soon fits occurred. As soon as it was sent home, however, the condition improved considerably, the condition before the accident returned, and since April, 1899, he had had no more fits.

The speaker attributed the recovery to the relief of pressure by the opening left in the bony skull, and considered the case to be one of aphasia associated with the imbecility of epilepsy.

Hr. Rose then showed a man who had been crushed in a railway accident. He had been crushed between a locomotive and an ash-box. Several ribs had been fractured, also a clavicle and the right arm. When admitted into hospital there was pneumohæmatothorax on the left side, hæmato-pericardium, and in the abdomen an air bladder covering the liver. Then vomiting came on, tenderness over the whole body, symptoms which gradually subsided. The blood in the pleural cavity gradually became decomposed, and a few weeks later 2,500 grammes were removed by aspiration.

Hr. Schüller made a contribution to the

ETIOLOGY OF TUMOURS.

Five months ago, from a giant-celled sarcoma, he had obtained a cultivation of a formation that he had since met with in other sarcomata, and also in a number of carcinomata of various organs, and which he associated with the ætiology of tumours. They were vesicular, yellow, or brownish bodies, strongly refracting light, of roundish or oval or irregular shape, with a firm covering, glistening white in appearance, showing circular lamination and radial markings. They were about four or five times the size of a red-blood corpuscle. They were coloured slightly in weak solution of hæmatoxylin and alum carmine. Beside these larger bodies there were also similar smaller ones, possibly early forms.

The bodies were obtained best when hardened pieces of tumour were teased out in alcohol. They then lay mostly between the cells, sometimes in rows, but generally solitary. In fresh preparations they showed changes of form, but no change of place. Animal experiments had, so far, led to nothing.

The speaker had also obtained forms from various syphilitic new growths primary as well, as gummata, which he considered of ætiological importance.

ASPIRIN.

Dr. J. Rubemann reports in *Therapie der Gegenwart* on the employment of aspirin in some dozens of cases of rheumatism in various forms, acute and subacute muscular rheumatism, in acute and subacute poly and monoarthritis, &c. His experience enables him to confirm the favourable judgment that has been passed on it. He recommends its use in addition in rheumatic neuralgias, sciatica, &c., that have hitherto been difficult to treat. The tablets, which are easily taken, break down into the form of powder on being mixed with water.

THE ALCOHOLIC TREATMENT OF LOCAL TUBERCULOSIS.

Dr. Neustadt (*Baden Med., Wochensh.* 7/1900) was led by the writings of Salzwedel, who introduced the treatment of phlegmons by the local application of alcohol to extend the application to local out-breaks of tubercle. He first employed it in a case of tendovaginitis and tuberculous osteitis of the left arm in a situation where local extirpation of the fungus was out of the question and amputation was the only alternative. The arm was dressed daily with

wadding well soaked in a 98 per cent. of solution of alcohol, over this was placed a layer of Billroth-Battist, and the whole fixed on with a bandage. In the same way, lint soaked in alcohol was packed into the fistulous openings present. At first the patient felt a burning that lasted till the evening, but did not disturb the night's rest. After six dressings, however, the burning was felt no longer. Even in three weeks a notable diminution of the swelling was observed, which continued. The pain also diminished, and the discharge from the fistula. Power of movement returned in the wrist joint (the part affected). After six weeks treatment one fistulous opening was completely closed, whilst into the second the sound could only be passed $\frac{1}{2}$ ctm., and the secretion was reduced to a very small amount. An unlooked for improvement was therefore obtained within the short space of, about six weeks, after other treatment had been employed without effect.

THE DIAGNOSIS OF EARLY TUBERCLE BY THE SPUTUM.

Professor Brieger and Dr. Neufeld have lately been working on this important subject at the Institute of Infectionen Krankheiten, and report thereon in the *Deutsches Med. Wochenschr.*, 6, 1900. In order to make examination of the sputum useful, it must be examined not only for the tubercle bacillus, but also for the exciters of the so-called "mixed infection." When bacilli are no longer found, the examination must still be carried out at longer intervals. In every case the clinical condition must be noted at the same time, as it is only by a consideration of both conditions, the clinical and the bacteriological, that diagnostic and prognostic conclusions can be drawn. In all doubtful cases the tuberculin proof must be made; this is quite free from danger, and gives certain evidence, i.e., it shows in any given case whether a simple catarrh is present, for instance from the influenza bacillus, or whether it is tuberculosis with mixed infection. A decision of the question whether a case was one of influenza alone or of tuberculosis with mixed infection was of immense practical importance from every point of view.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, March 31st, 1900.

PAPILLOMA IN BLADDER.

At the Gesellschaft der Aerzte, Weinlechner presented a patient from whom he had removed a papilloma about the size of an almond from the bladder. It had occasioned extensive hæmorrhage for some time followed by cystitis that increased the gravity of the case. Sectio alta was performed, and as much of the pedicle removed as possible. The wound soon healed but the cystitis still persists. He thinks this case would have got on better if he had stitched the bladder and left in a drainage tube for a time for the purpose of washing and cleansing the viscus.

THE FUNCTION OF GASTRIC SECRETION.

Kreidl demonstrated to the Society by means of a dog which he had prepared for the occasion, the functional activity of the gastric glands of the stomach. A fistula had been established between the fundus of the stomach and the surface whereby the process of digestion could be accurately observed. It was shown that simple mechanical irritation had no effect on the secretion of

the organ, but if fluids were presented, such as beef extracts or broth, the flow was profuse. The psychical influence is immense; if the food be presented or its preparation exhibited five minutes before ingestion the flow of secretion is very great.

BLOOD PRESSURE OF THE INSANE.

Piley next gave a history of his experiments on the blood pressure of the insane. His experiments were conducted with Gärtner's tonometer. At the commencement of progressive paralysis the blood pressure is normal, though at the lowest limit, but as the disease progresses the pressure gradually sinks till approaching the end, when it suddenly falls to a very low point. This observation can be practically utilised in the prognosis of a case; if the blood pressure remain high, notwithstanding the gravity of other circumstances, it may safely be prognosticated that the lethal point is not at hand. Piley related several exceptions to this rule where the patient suffered from morbus Brightii, and a depressed melancholy form of the paralysis. The modifying influence of the phrenic keeps the pressure at the normal limit during the moderate progress or incipient stage of the disease, but rapidly sinks during the period of excitation.

In the circular form of insanity during the maniacal stage, the pressure is also reduced, and in melancholia may vary between 60 and 170 millimetres of mercury. In epilepsy, during the spasm, the highest register is 120 to 150 which will sink in two or three minutes to the normal point; the pressure is thirty to thirty-five lower during sleep than in waking hours.

Federn remarked that the fall of blood pressure before death was not confined to this disease alone, as it only pointed to a loss of sensation in the vasomotor centres. As a high blood pressure causes constriction and distension about the chest, it is probably the melancholia that is the primary cause.

A contracted condition of the bowels does not play an unimportant part in the disease, as opium acts like magic in relieving this agonising depression.

Jauregg said he could never associate increased blood pressure with any condition of the bowel. It is more probable that the increased pressure is a secondary expression, while the primary is psychical.

Baeh was inclined to agree with Federn. The increased pressure may arise from a variety of causes, and possibly causes outside the psychical sphere may act on that centre which would raise the pressure which ultimately may be the primary cause, thus producing a sort of circulus vitiosus in the origin of the disease.

CYSTIC IRIS.

At the Medical Club, Bondi exhibited a patient, æt. 42, with a cyst in the iris. The history of the case was that the patient consulted a doctor about his left eye last July, who diagnosed a malignant tumour, and advised enucleation of the bulb, to which the patient would not consent. The tumour still increased and became painful when he came to the "Klinik" to have it removed. The tumour was about the size of a pea, and perfectly filled the anterior chamber. On examining it with a lateral light the margins were observed to be transparent, which proved its non-solidity and negatived sarcoma.

Early operation is indicated as the growth is likely to increase the pressure and produce secondary glaucoma.

The operation need not be enucleatio bulbi, but a simple removal of the cyst.

Continental Notes.

[FROM OUR SPECIAL CORRESPONDENT.]

THE AUSTRIAN TYROL.

THE health-resorts in the Tyrol really merit more attention than they have generally received in England. Both Innsbruck and Meran are becoming better appreciated among us; but some of the other stations are to many of our people almost unknown.

INNSBRUCK AS A HEALTH RESORT.

In an article published in the *Semaine Medicale* of Paris, Professor Jaccoud speaks very highly of the value of the Innsbruck climate as a preventive agent "for those predisposed to pulmonary phthisis, and of the advantages of Innsbruck to persons in good health who need having their constitutions built up as a merely preventive measure." He does not believe in confining these in rural or semi-rural districts, when equally good climatic advantages can be found as at Innsbruck, combined with amusements and intellectual advantages of a city. Like the old French philosopher, he thinks evidently that a large proportion of the beneficial effects from a sojourn at any spa, or health station, may be attributed to the "beautiful scenery, the enlivening society, and the good living found there." All these are at Innsbruck; especially the "good" table and other material comforts at the Grand Hotel Europe and the Hotel Tyrol, both conveniently situated in the spacious Railway Station Square at Innsbruck.

THE OBERAMMERGAU PASSION PLAY.

Just now Innsbruck is preparing for the Oberammergau Passion Plays of May, June, July, August and September. Oberammergau is within 12 hours drive from Innsbruck, by a picturesque mountain route. And either going or returning by making a day's detour, the interesting Royal Palaces in the Highlands of Bavaria can be included in the excursion. All details of these Chateaux, and of the Oberammergau Festivals, will be gladly furnished by Mr. Harreich, of the Hotel Europe, or Mr. Landsee, of the Hotel Tyrol, Innsbruck.

From Innsbruck the main railway line to Italy runs southwards over the Brenner-Pass. From this line to Botzen Junction (good hotel "The Victoria," opposite railroad station at Botzen), a branch rail goes to Meran; the most famous health station in the Tyrol. Probably nowhere else in Europe can be found amidst superb scenery, and so primitive a population, so much *fin-de-siècle* civilisation and abundance of modern comforts.

MERAN.

Meran can show a dozen excellent hotels, varying in style, terms, and situation; pre-eminently the Hotel Erzherzog-Johann (admirably kept by its owner, Mr. Wenter), with, added to its long-time renown, recent elegant equipments, new marble exterior, and attractive gardens. Meran lies in the Adigé (Etoch) river, at an altitude of 1,050 feet above sea level. North, east, and west of it rise precipitously mountains to heights of 6,000 to 9,500 feet. Southwards opens a broad valley of fertile farms and fruit gardens; and, on the hill sides, terrace upon terrace of vineyards. The "grape-cure" is a

speciality of Meran. On every hill-top and rocky peak are ancient chateaux; and on every mountain slope and brook side are pleasant promenades, marked and graduated and amply provided with seats for the advantage of pedestrians; the "earth-cure," or gradually increasing walking "prescriptions," being another speciality of a "cure" at Meran. Besides the broad valley southerly, two other valleys concentrate here; so that walking exercise can be readily taken on level ground, on gradually ascending slopes, or on more abruptly rising pathways.

Thirty-four miles south from the Botzen Junction (on the main line from Innsbruck to Verona) is another junction station at Trient, the seat of the famous ecclesiastical "Council of Trent." From Trient a railway line runs eastward, past the Roncegno Spa (ferruginous-arsenical waters), of which more will be said subsequently. Eighteen miles yet more southerly from Trient on the main railroad is the junction at Mori, whence a branch line diverts (going for part of its route through a most curious chaotic country) to Arco and to Riva on Lake Garda.

ARCO AND RIVA.

Arco, several miles north of the lake, is a rapidly rising health station. This is evident from the new buildings, promenades, and other improvements. It is well supplied with hotels, pensions, churches, casino, &c. The latest hotel, "The Cur-Casino," is under the able management of Mr. Carl Brunner, who at New York, Stirling, and Edinburgh has made himself acquainted with Anglo-Saxon notions of how a good hotel should be kept. Arco is fully protected north, east, and west by mountains, and lying open to the warm Italian breezes and the southern sun, has special recommendations to pulmonary patients, and to delicate constitutions needing an unusually mild and steady climate. The vegetation all around it speaks for its semi-tropical advantages. The season at Arco is only for winter and spring. Among the resident physicians is Dr. Heinrich Wollensack, who in the summer has charge of the Hydropathic Establishment at the Giessbach Falls, on Lake Brienz, near Interlaken.

Riva (four miles south of Arco) is an ancient town on the banks of Lake Garda, a very pleasant home for spring, summer, and autumn. This April the newly-erected and elegant "Imperial Hotel Lido" will be opened here, amply equipped with every latest improvement, electric interior-ventilation as well as electric lighting, baths on each floor, thorough sanitation, photographic rooms, central heating; and is in the midst of beautiful gardens of palms and other evergreens, on the lake shore, sufficiently outside the old town to avoid mediæval surroundings, yet within five minutes' walk of railway-station and steamboat landing. This hotel will be open all the year round, and have an able resident physician. Riva is recommended for its dry climate to sufferers from heart and nervous complaints, and also especially to convalescents and the over-worked; but not for lung diseases. Lake-bathing, fishing, boating are good. Riva is the threshold of attractive Alpine excursions, as yet insufficiently known to the great majority of British tourists. Its vicinity is geologically and archaeologically interesting. Two good steamer routes commence at Riva; one down the east side of the lake to Peschiera, and another down the west coast to Desen-

zano. Both Peschiera and Desenzano are stations on the railroad from Milan to Verona and Venice.

The west shore of the lake is the more picturesque. On this shore is the "Riviera of Lake Garda," a narrow strip of land between the hills and the lake, famous for its luxuriant vegetation and particularly for its unsurpassed lemon cultivation. This Riviera commences at Gargnano, and terminates at Salo. As a winter resort it has many charms. There are two desirable hotels; the "Hotel Salo" (near the ancient town of Salo), amidst fine grounds on the shore; and at Gardone the spacious "Grand Hotel Gardone Riviera." There are a variety of smaller hotels and pensions. One, the Pension, "Villa Sonnenburg," of Madame Gazert, being in every way very superior. It stands in charming grounds overlooking the lake, but not immediately on the water-side.

The Operating Theatres.

KING'S COLLEGE HOSPITAL.

WIRING FRACTURED OLECRANON.—MR. CARLESS operated on a woman between 50 and 60 years of age, who was the subject of a fractured olecranon. She had fallen and struck the point of the elbow against the pavement twelve days before, and the olecranon was detached at the base, and there was a great deal of effusion into and around the elbow. The ecchymosis had extended widely among the extensor muscles of the forearm. The limb was very thoroughly and carefully purified, and a curved incision was made on the inner side in such a way that when the flap was turned up the inner aspect of the olecranon was exposed. A certain amount of organising blood clot, which was lying between the ends of the bone was removed and the joint freely opened. All clot being taken from its interior, the ends of the bones were scraped and freshened up, and tracks were drilled through the fragment and through the shaft of the ulna with bradaws in such a way that the awls emerged close to, but not through, the articular cartilage; thick silver wire was then passed through these tracks, and after the forearm had been extended and the fragment pressed down to the shaft, the wire was drawn tight, tied in a knot, and the ends cut short and hammered down into the periosteum; the cutaneous flap was then replaced and stitched in position without drainage, the usual antiseptic dressing was applied, and the limb placed on a splint which kept it in a position a little short of full extension and with the hand pronated. Mr. Carless remarked that in wiring either the patella or the olecranon it was desirable that a week or ten days should elapse from the time of the accident so as to allow the joint to recover from the shock and injury inflicted upon it. It is also most important to remove all the blood clot in the joint and any organising material which may be found between or plastered down on the broken surfaces, so that actual osseous tissue may be exposed. The tracks of the wire must not encroach on the articular cartilage, and the greatest care must be exercised in bringing out the wires at the same level, otherwise a ridge will be formed in the articular surface, which will interfere with the subsequent free mobility of the joint. Mr. Carless prefers the use of silver wire in such cases to that of screws, which must be more difficult to sterilise. He also drew attention to the flap incision which he had

utilised. It is undesirable, he said, in dealing with either the patella or with the olecranon, to make a central longitudinal incision which would subsequently lie over the line of union in the bone; an internal flap answers all the purposes required in this operation most perfectly, but, of course, the surgeon must remember that the ulnar nerve is not far away and must be careful that his flap is not too thick.

The wound was not dressed for eight days, and was then found to be healed. The stitches were taken out, and a small collodion dressing applied, the splint was removed, and the patient was encouraged to move the limb herself. On the fifteenth day from the operation she had complete natural range of movement restored, and was entirely free from pain. Mr. Carless subsequently pointed out that a result such as this in a woman over fifty is a great contrast to the course of a case treated in the old-fashioned way by splints and prolonged immobilisation.

WESTMINSTER HOSPITAL.

OPERATION FOR MASTOID ABSCESS.—ATTICO ANTRECTOMY.—MR. DE SANTI operated on a man, æt. 20, sent up to him by Dr. Morton, of Chelsea, with a right mastoid abscess. There was a sinus behind the ear with much swelling and oedema and evidently pent up pus. There was the usual history of chronic purulent otorrhœa for some 15 years. The patient having been anaesthetised an incision was made round the back of the ear down to the mastoid process and the whole of the ear turned well forwards, its deeper cartilaginous portion being detached from the deep bony meatus. It was then discovered that the sinus led to the deeper part of the cartilaginous meatus and not into the mastoid antrum. The mastoid antrum was opened up in the usual way, some cheesy sour material turned out; the attic was next thoroughly opened up and the whole of the parts thrown into one (attico-antrectomy). All pathologically diseased tissue having been removed, the part was packed with dry iodoform gauze, and the ear restored to its original position. Mr. de Santi said that in cases of chronic purulent otitis media without any complications, every care and attention should be paid to the curing of the condition by therapeutic measures applied through the external auditory meatus, but this was very difficult to carry out efficiently in out-patients; in cases, however, in which the intractable nature of the otorrhœa is due to the impossibility of getting at the whole of the affected suppurative area, he thought the radical cure of the affection (attico-antrectomy) was called for; the danger to life of this operation he felt justified in saying was extremely slight, although there are many important structures in the vicinity of its field such as the facial nerve, the internal ear, the lateral sinus and the brain; the hearing, he pointed out, was considerably improved in a large proportion of cases after attico-antrectomy. In the patient on whom he had just operated the existence of the sinus behind the ear was, he remarked, an additional circumstance that rendered the operation justifiable.

THE Quarantine Authority of Egypt has thrown open to competition among medical women a post under the department at Suez at a monthly salary of from twenty-two to twenty-eight Egyptian pounds.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, APRIL 4, 1900.

OUR MEDICAL SCHOOLS.

It is no doubt a question of much interest to the public and the profession to what extent our hospitals should be regarded as schools of medicine. In old days schools were separated from hospitals, though physicians and surgeons who carried on their teaching in their old schools, as in the days of the Hunters, were generally dependent upon hospitals for that part of the education of their pupils which is included under the general term of clinical instruction. Within the last half century a new class of hospital has come into existence, to which schools are not attached, and where special forms of disease are made the subjects of treatment. The general hospitals, as schools of medicine, have suffered much from this cause; while that great class of maladies which is most important to those preparing for practice, namely, the infectious fevers, is not under the care of the physicians attached to our schools of medicine, or, at least, the cases are not now admitted into the wards of general hospitals. It is not easy to arrange for this separation of cases where the education of medical students is an object of interest. It can be understood that advantages are offered by special hospitals to those whose chief interest lies in the investigation of the nature of a special malady, and who are supplied with far greater resources by a special hospital than they could obtain from one where every kind of malady is admitted. Some men excel as original observers, and some as teachers, and we can understand why special hospitals are attractive to one class more than to the other. There is also another reason why special hospitals are in favour with some members of the profession. It is because the public is disposed to resort to those who specialise in their knowledge, and as a matter of

"business" there is far more profit to the specialist than to others who have no reputation by which the public is attracted. We see occasionally a decided preference shown by some for specialism both in medicine and surgery, and the general hospital with its school attached is resigned in favour of the special. It is, however, a matter of great public interest that our students should be well prepared for the demands of general practice. If hospitals are regarded as of chief value from the public reputation they bring to those attached to them, and where it is of little interest to use them as sources of instruction, the consequences will be felt by the public. The first and prime purpose of a hospital is undoubtedly to relieve the sick; but it would not be difficult to persuade those sensible and charitable people on whom hospitals chiefly depend, that they are doing a public service by allowing the study and teaching of medicine and surgery to be conducted within the walls of hospitals. We believe that no class of men are better qualified to treat the poor and the sick with kindness and consideration than those of the profession who have been leaders in the hospital practice of this country; and we trust that nothing will be done to lead to doubts in any minds that such principles of conduct as characterised the past are changing in the present. We fear that our schools have suffered of late by the teachers being deprived of the chief interest they once felt in their pupils to some extent by the rise of specialism, and to some by the system of examinations which takes the students away from the kind of work which would be of most use to him in practice. Some attention ought to be given to this subject by those to whose care the education of our students is entrusted, so that the great advantages of our hospitals as schools of medicine and surgery should not be neglected, and the opportunities they offer, and which are not easily obtainable in later life should be turned to the greatest practical good.

"EXPERIMENTS" IN HOSPITALS.

THE attitude of the average layman in matters medical presents a curious blending of credulity and assurance. Regardless of the fact that a knowledge of medicine can be gained only by long study and toilsome experience he is ready to advance strong views at a moment's notice upon any subject connected with the medical profession. In this way he physics himself and his friends with easy confidence, and is never at a loss for a diagnosis in the shape of some popular symptomatic ailment. Such a man would never dream of expressing an opinion upon astronomy, or chemistry, or mensuration, or any other highly technical branch of knowledge outside his own intellectual sphere. It is only when he comes to the most complex and difficult of all arts and sciences, to wit, applied medicine, that he assumes the robe of self-sufficient wisdom. With the result of amateur doctoring all members of the medical profession are only too painfully familiar. As an example, we may take the vast number of cases of mis-called "rheum-

matism," treated as such by quack remedies, whereas they are in reality symptoms of grave organic or constitutional disease demanding the promptest skilled attention to afford any chance of recovery to the sufferer. Hardly a week passes in busy practice without cases of the kind coming under notice when they have reached a stage too late for medical assistance. Were it not for the existence of an enormously wide class of amateurs ready to assume the responsibilities of the physician, the vendors of quack medicines would not be able to amass vast fortunes at the expense of the health and happiness of the community. Mischievous persons of that ilk recruit the ranks of the anti-vaccinationists, who are prepared to go to any length in support of their unskilled conclusions in defiance of practically the whole world of scientific medical opinion. So, too, with the anti-vivisectionists, who denounce the medical profession root and branch because of their distorted views of the relative value of life in the human being and the brute. These sentimentalists see no harm in slaying lower animals for food, often in a deliberately cruel and brutal way by way of sport, or in order to obtain fur or feathers for decorative purposes. They allow that noble animal, the horse, to be harnessed and driven about hither and thither, not unfrequently under circumstances of refined and revolting brutality, to serve as a beast of burden and of traction. They cause wild animals to be trained in menageries and pay for the privilege of witnessing lion-tamers engaged in sensational performances that invariably end sooner or later in the ghastly death of a fellow human being. Yet these same people declaim ceaselessly against the sacrifice of a few of the lower animals in the endeavour to protect and save human life from suffering and premature death. The curious part of it is that the evidence from which they have jumped to their conclusions has been simply that furnished by sensationalist writers of the "torture-trough" and "disembowelling" type. We venture to say that Lord Coleridge and his brother sentimentalists have no sufficient knowledge either of what experiments upon lower animals are performed in the United Kingdom, or of the conditions under which they are carried out. Otherwise they could not possibly hold up an honourable and humane profession to public scorn and condemnation in the way they are wont to do. But the all-sufficient anti-vivisectionist is not content to stop at that point of his folly. He goes on to accuse the medical profession of wholesale experimentation upon hospital patients, and he leaves no stone unturned that may help him in his monomania. Recently he has appealed to the prejudices of the Metropolitan Radical Federation, representing some 50,000 members of working men's clubs and associations in London, and he has so worked on their scientifically untutored understandings as to persuade them that experimentation on human beings is carried on to a large extent in the medical charities in the United Kingdom. The Federation have accordingly sent a memorial to the Prince of Wales, pointing out that there was a tendency among doctors and students at the London

hospitals to regard the patients as so much material for experiment. The ridiculous nature of such a charge, unsupported by a tittle of evidence, is self-evident. In a certain sense every trial of a remedy or a particular method of treatment where the results cannot be mathematically foretold constitutes an experiment. Where there is any serious risk to life involved the decision is left to the patient or his friends. So far as students are concerned they work under supervision, and are not allowed to make experiments upon patients, as the Federation suggests. Nor does the august body that assails the medical profession with so terrible a charge appear to be happier in its aspersions upon the honorary physicians and surgeons of the hospitals. No one who is acquainted with the lives and the work of the men thus singled out for attack, could for a moment entertain the suggestion that they would play fast and loose with the lives of patients entrusted to their care in the hospital wards. The whole memorial appears to result from the stirring up of narrow and ignorant prejudices upon the flimsiest grounds. Medical men experiment upon lower animals and thereby act in an inhuman manner, what more natural than that they should proceed to experiment upon human beings? Such appears to be the proposition upon the strength of which the Prince is asked to cut off the supplies to the London hospitals. How the members of the Radical Federation are to find succour in their hour of need when the hospitals are shut up does not appear on the face of their precious memorial. There is some ground for their further complaint that funds given to the hospitals are diverted to the support of medical schools. The existence of such a state of matters, in our opinion constitutes a substantial ground for searching inquiry, but it is a matter apart from the question of experimentation upon hospital patients, and merely confuses the issues that vex so deeply the inner conscience of the Radical Federation.

THE FUTURE OF THE ASYLUM SERVICE.

[THIRD ARTICLE.]

A GREAT outcry has arisen, especially in London and in connection with the London County Council Asylum Service, for an eight hours day. It seems to be the rallying cry of all kinds of service, and while it is a conceivable good, and a conceivable possible in many cases, it can only be regarded as a conceivable good, but a conceivable impossible as regards asylum service. In speaking to honest, conscientious attendants on the subject one is struck by the unanimity of their opinion that an eight hours day in asylum work would not be for the good of the insane. The fact of the matter is that when there is a change of staff, there is a change of knowledge of the patients, and a change of responsibility. It is the anxious desire of the medical officers to see that those who take over the responsibility of the patients know fully all about them, what to provide for, what to guard against, what nursing and attention is to be given them.

Now in large asylums there are two changes a day; there is the morning change from night duty to day duty, and the evening change from day duty to night duty. That of course means two changes of responsibility and knowledge of the patients, two reports for the previous twelve hours to be inculcated to the incoming staff by the outgoing staff, and there is a risk of the patient falling between two stools owing to deficient inculcation, or deficient knowledge of changes which have occurred in the interim. When one considers what risks are run in the treatment and management of insane people, it is conceivable that to increase the changes to three in twenty-four hours would be to increase the risks, slacken the responsibility, and to do the worst thing possible for the insane. We are quite prepared to admit that the hours of duty are longer than in most public services, and in some cases that the work is arduous, but the latest tendency of the present day asylum administrations is to multiply the staff, to share arduous duties by changes every two or three hours, to increase the leave off duty, and to shorten the daily hours during which attendants are in charge of the insane. While, therefore, it is not practicable to limit the hours of duty to eight hours daily, it is possible at certain times when the demands on the staff are not so great to let so many off duty earlier, and to give them extra leave in other ways. With a large night staff it is possible to let day attendants off duty an hour earlier than has been the custom hitherto, and it is quite possible to let nurses and attendants on their Sunday off, free for the whole day. Indeed, there is nothing to hinder them getting off from the Saturday night till Monday morning when it is their Sunday off duty. There is no question that in the future of asylum service the hours of duty will be greatly reduced by increasing the leave; week ends will be given as frequently as possible in addition to the weekly half-days, Sunday leave will be total not partial, and holidays will be given on a more liberal scale than formerly, and sick leave will be allowed except in cases where there is a tendency to malingering, and where there has been abuse of the privilege. There is also evidence of broadening views in other directions. When trouble comes into an attendant's or nurse's family, the nurse may be asked to go home and nurse a sick relative, and when formerly she had asked away, it was frequently refused, with the result that the nurse often took French leave. Now the tendency is to give leave in such cases, and also to grant leave in the case of an attendant or nurse recovering from illness, but, of course, it is not necessary that the pay should continue during their absence from the asylum, if that is prolonged. It is true also that attendants and patients are more considered now during the holiday season, by increasing the staff temporarily, and that more encouragement is given to attendants and nurses to go outside to dances and other social functions, and to mix with their fellow creatures outside, as well as a great many other ways too numerous to mention. The question of an eight hours day, therefore, though an impossible one, has

raised the general question, and the result will be, sooner or later, to the advantage of all concerned.

Notes on Current Topics.

Clinical Teaching in the Galway Medical School.

WE hear that a serious hitch has occurred in the working of the medico-educational system in connection with the Queen's College, Galway. It will be recollected that some years ago a violent controversy took place as to the Galway County Infirmary and the Union Workhouse, which resulted, after long delay and much acrimony, in a reconstruction of the constitution of the administration of the Infirmary, the so-called popular element being admitted to authority therein, and the Medical Officers of the Workhouse, as well as the Medical Professors of the College being admitted to free warren over the beds of both institutions for the purpose of clinical teaching. The arrangement appears to have worked well, and the combined institutions were able to fulfil all the requirements of the licensing bodies until peace and efficiency has been, recently, brought to an end by the inevitable politico-religious wrangle. The position of matron to the County Infirmary (*alias* County Hospital) became vacant, and a Sister of Charity was appointed to the vacancy by the Hospital Board, but the Local Government Board refused its sanction, as it has steadfastly done throughout Ireland in similar cases, because the lady was not a trained nurse. The governors, however, adhere to their determination to have no one but a Sister of Charity, while the guardians, who have charge of the workhouse, have clinched the business by shutting the doors of the institution against the Queen's College students just in the middle of their winter session. It requires a Galway Poor-law guardian to understand the reason why a medical student should be deprived of the means of learning his profession because the Local Government Board regards competency in a matron as of more importance than religion, but so it is and as no intelligent being can have any sympathy with this subserviency of all public affairs and all philanthropic considerations in Ireland to politico-religious influences, we trust that the licensing bodies will see their way to make such concessions as may be consistent with their regulation to enable the Galway students to complete their education. To the outside observer it must be a melancholy spectacle that nothing, however meritorious, can be done in Ireland without the noxious intervention of extraneous influences.

Another Registration Bill.

ONE more of the projects of law, of which the Plumbers Registration Bill and the Midwives Bill are fair samples, designed to create monopolies for the benefit of a clique, is presented to Parliament in the form of the Professional Accountants Bill. It goes, however, much further than either the Medical Act, or the Dentists Act, or the Midwives Bill.

because it forbids everyone after a certain date to practice as an accountant without being registered, and it excludes from registration everyone who cannot *prove* that he was so practising at the date of the passing of the Bill. There is an essential difference between such a law and those laws heretofore recognised by Parliament, for we know that the Medical Act does not forbid anyone to practice, and that neither the Dentists Act nor the Midwives Bill demand *proof* of being engaged in practice. It is enough that persons desiring to be registered shall state that they are so engaged. It seems to us that the system of official registration is being reduced to an absurdity when a plumber cannot be allowed to solder a gas pipe or a clerk to tot columns of figures without paying registration fees to the wire pullers of his trade.

Unprofessional Conduct.

A DOCTOR and a chemist at Elberfeld, in Germany, were recently placed on their trial on a charge of having provided a number of conscripts with medicines, which would entail their rejection by the "medical board" without inflicting any permanent injury. In countries where military conscription is the rule many are the devices resorted to for the purpose of escaping the dreaded service and army doctors are trained to be on their guard against frauds of that kind. As a correspondent points out, a recruit in England who is rejected for active service is not, as a rule, grateful to the medical official who rejects him, but this is just the difference between voluntary and compulsory recruitment. The prisoners may, for aught we know, have been inspired by the example set by the monk in *Hamlet* in his well-meant attempt to facilitate the union of two lovers, but the result in that instance was tragic enough to have suggested reflection. That opportunity for reflection they will now have, but like so many of these opportunities it comes too late to serve them in their need.

The School Boards and Eye Hospitals.

THE special care which the London School Board now devotes to the eyes of the scholars, an innovation which is worthy of the highest commendation, has had for effect to throw a great additional burden on institutions founded for the treatment of defects and diseases of that organ. It is evident that the addition of a few hundred additional patients with errors of refraction requiring to be corrected is apt to embarrass the staff in their duties, and one can quite understand that a cry has arisen for the creation of an eye department under the control of, and subventioned by, the Board. This proposal Miss Honnor Morten sharply challenges on the ground that if the voluntary hospitals cannot or will not deal with such an important thing as the eyesight of the poor it is time to set about instituting municipal hospitals under a hospital rate. The logic of this statement is not quite apparent for the inability or unwillingness of existing special hospitals to discharge these extra duties does not

necessarily infer the obligation to create municipal hospitals. If the School Board will vote funds for this special purpose just as would any large employer of labour many of whose employes habitually availed themselves of hospital assistance, no doubt the managers of these hospitals would display every willingness to discharge the functions asked of them. We really do not see that the School Board is entitled to ask assistance of this kind without contributing to the maintenance of such institutions, and a simple way out of the difficulty would be either to subvention certain special hospitals or else to open a special department of its own though whether specialists would be willing to give their services gratuitously under such circumstances is open to question.

A Mistaken Prosecution.

DR. R. M. FREER, a Walworth practitioner, was charged last week at the local police court with having neglected to notify a case of diphtheria under his care. It appears that in stating the cause of death diphtheria was entered as the primary cause, although, as a matter of fact, the child having suffered therefrom was purely a matter of inference, the actual condition having been diagnosed as post-diphtheritic paralysis. The case was dismissed, but we cannot help thinking that much trouble might have been averted if Dr. Freer had appended a note to the certificate explaining the circumstances under which the diagnosis was arrived at, or, better still, if, by the aid of a note of interrogation, its hypothetical nature had been made manifest. On the other hand we think it would conduce to harmony and economy if the Medical Officer of Health, before instituting a prosecution, took the trouble to communicate with the certifying practitioner. No good result can possibly accrue from unnecessary proceedings of this kind, and it behoves members of the profession to carefully avoid doing anything that will tend to cause friction between themselves and those who have charge of the public health.

The Over-Worked Consultant.

A LAY contemporary draws a vivid picture of the over-worked consultant inhabiting the environs of Cavendish Square who, it is stated, is obliged to sacrifice comfort and health in the discharge of unremunerative duties. The public have no idea we are assured of "the amount of money, energy, and pleasure which has to be given up in deference to the profitless duties which Society demands from the celebrated." We are free to admit that we are unable to define the nature and scope of these multifarious duties imposed by Society (with a big S) on the reluctant consultant. No doubt hospital duties, self-imposed, consume a large amount of time and energy and the writing of books, the preparation of papers for medical societies and contributions to ephemeral medical literature prevent the busy consultant from going to dances and disporting himself as frequently as he could wish on the river or on the cycle. Still these occu-

pations are all of his own choosing. Far from interesting himself to any overweening extent in public affairs we have but too often to complain of the apathy in matters of local and national concern. We question whether there is a single consultant on the St. George's Vestry or Board of Works or Guardians, with the inevitable result that their streets are badly kept and are lighted in a way that would not do honour to an East-end parish. All this, however, is doubtless part of the scheme of the universe for fame is only to be achieved by persistent and sturdy efforts to keep one's name and personality before the public.

Ptomaine Poisoning.

UNLESS chemists and physiologists speedily make some headway in the study of that mysterious class of toxic agents vaguely described as ptomaines the public will possibly conclude that, as an explanation of certain lethal effects, it is the refuge of the destitute. It is curious, to say the least, that both bacteriology and chemistry should afford no substantial clue to these remarkable bodies, the presence whereof is inferred from their presumed effect, and that only. The present state of our knowledge, or rather of our ignorance, on this subject, is attended by risks to the public against which no precautions yet devised are of avail and it introduces unforeseen contingencies into commercial enterprise in regard to the sale of aliments capable of undergoing the changes which culminate in the production of these deadly toxins. As matters stand certain precautions suggest themselves as worthy of adoption by those who cater for the public in things gastronomic. One is the desirability of closely inspecting the meat and fish supplied, and the propriety of storing them elsewhere than in a hot kitchen, even though a refrigerator be employed. Another point elicited in a recent trial is that cans of preserved fruit and vegetables ought to be consumed on the day they are opened, and not "carried forward" under any circumstances. In the absence of any evidence of want of care on the part of those who are responsible for hotel supplies, it seems unjust to saddle them with the damages caused by bacterial mischief which experts confess they do not understand, and of which they are admittedly unable to scheme the prevention.

Preservative and Colouring Matter in Food.

AT present there is urgent need for more light as to the precise action upon the human body of preservatives and colouring matters used in food. The attempt to solve the problem by means of the Departmental Committee appointed by the Local Government Board does not seem destined to meet with any great measure of success. The fact of the matter appears to be that scientific research has not hitherto provided sufficient data upon which sound conclusions may be based. As things stand there is little beyond assumption and speculation as to possibilities and probabilities so far as concerns the action of many even of the commoner preservatives, such as boric acid, upon the human body. One

suggestion advanced apparently in all seriousness by a Medical Officer of Health in the north of England is typical of the loose reasoning with which an obscure subject is often approached. He connects the increase of infantile mortality in the third quarter of the year to the greater use of preservatives in milk and cream. The excessive mortality of that season is mainly due to epidemic diarrhoea, a disease of multiple microbial origin. The infection is probably air borne and is often conveyed by the agency of milk, which offers a most suitable medium for micro-organisms. So that the cause of the increased mortality is the bad milk and not the preservatives added to correct the milk. It is to be hoped that the whole of this important subject of added foreign matters to food will ere long be investigated by competent scientific observers.

Hæmophilia in the Negro.

AS long ago as the year 1820 an attempt was made to collect all the reported cases of hæmophilia, by Naas, a German physician. Since then several other writers have at intervals carried out the same task. Of the races represented in the list, the Anglo-Germanic has furnished the most cases, but it is curious to note that throughout the literature upon the subject there are only two cases recorded as having been met with in the negro. The first was that of a mulatto boy, æt. 7, reported by Hadlock, of Cincinnati, in 1874, where the diathesis became manifest after the extraction of a tooth, death subsequently following. The second case is published in the February issue of the *Johns Hopkins Hospital Bulletin*, for the current year, by Steiner. But the latter writer points out that in neither case the hæmophilia was in patients of pure negro blood. In his own case the patient's great-grandmother was a bleeder, of Scotch nationality, who married a Guinea negro, while her grandmother, also a bleeder, married an Irishman. Thus she was far removed from a pure negro stock, although she is described as a "quite well developed, dark skinned negro girl." The form in which she was troubled with hæmorrhage was epistaxis, but it had never assumed a serious character.

The British Dietary.

SOME interesting investigations have been carried out by Mr R. F. Crawford upon the subject of the comparative dietary of the inhabitants of the United Kingdom, Belgium, France, and Germany. In these islands we appear to eat, upon an average, more meat than do the Belgians, French, or Germans, but, on the other hand, less bread and potatoes. Belgium takes the lead in the consumption of bread, while in Belgium and Germany the consumption of potatoes is about three times that in Great Britain. A curious feature also is the small consumption of milk in France. Perhaps now that these facts have been made known with respect to the food-consuming qualities of the races named, someone will be induced to make similar inquiries regarding the consumption of alcoholic beverages.

Lady Chemists.

THE *Chemist and Druggist* calls attention to the transfer of a chemist's business at Crediton under the very exceptional circumstance that the two owners were maiden ladies who nevertheless carried on the business with marked success for the greater part of a century. This episode controverts the suggestion of our contemporary that women may make excellent pharmacists but bad traders, and that they are incapable of making a commercial success under difficulties. This may be true of large commercial ventures, but we have not the least reason to suppose that the average female student is incapable of learning pharmacy, or of performing all the manipulations necessary for dispensing, or keeping the books and accounts of a small shop, and we adhere to the opinion that pharmacy, combined with the sale of toilet requisites and the usual stock of the chemist's trade, is a means of livelihood likely to prove lucrative to the lady student who has a little capital at disposal.

The Queen and the Royal College of Surgeons, Ireland.

THE Council of the Royal College of Surgeons in Ireland has, in honour of her Majesty's visit to Ireland, and upon the petition of the candidates for examination at the College, decided to relax the regulations so far that candidates who have already passed or shall before July 31st pass their second examination under the Conjoint Committee of the Colleges (which comprises the subjects of the primary fellowship examination) shall be allowed credit for the last named examination, and shall be permitted to proceed to the final fellowship examination when they shall have completed their education, obtained their diplomas, and otherwise complied with the regulations in payment of fees and other matters.

Sharp Work.

MR. G. A. PATON, practising in Southwark, had an unusual experience last week, judging from his remarks to the coroner in giving evidence at an inquest. He was called to a case at 9 a.m. on the Wednesday, only to find the patient dead on his arrival. On the way back he was called to a second case in which the death had already supervened, and before reaching home again he was summoned to a third case in which the patient had also predeceased his arrival.

An Unusual Claim for Damages.

A REMARKABLE case recently engaged the attention of the law courts in Paris. A certain physician prescribed a mixture containing a small quantity of atropine, into which the chemist, by error, introduced a poisonous dose of the alkaloid. The first dose rendered the patient very ill, and the medicine was incriminated, whereupon the doctor, to show his good faith, swallowed a quantity of it himself, with disastrous results. The error was admitted, and damages were awarded to the patient, but the doctor also claimed damages for the injury done to himself

a claim which was resisted by the erring pharmacien on the ground that he had brought trouble on himself by doing that which it was no part of his duty to do. The question is a delicate one, and, so far, the judges have not arrived at a decision.

Secret Commissions.

THE Bill of Lord Russell of Killowen, to prohibit illicit commissions on trading transactions, which was read a second time in the House of Commons last year, was reintroduced and read a first time last week. We have already, in the absence of any evidence that such commissions pass between the medical profession and those with whom it has dealing, have emphatically repudiated such a statement, but we shall be well pleased if, in the future, Lord Russell's Bill shall make such traffic an impossibility.

Leprosy in Crete.

THERE are said to be no fewer than 2,000 lepers in the island of Crete, and under the Turkish Government, the lot of these unfortunate sufferers is not as favourable as it should be. No system of segregation seems to be carried out, nor are any special arrangements in force for the care of the lepers. It is in contemplation to invite the Danish leprologist, Dr. Edward Ehlers to visit the island and organise some system by which the sufferers can be properly looked after.

The Medical Students' Register.

ACCORDING to the figures given in the "Medical Students' Register" just issued, the increase in the number of students for 1899 as compared with 1898 is only 102. If, instead of comparing the numbers year by year we take the two quinquennial periods ending 1894 and 1899 respectively, we find that during the former period the number was 9,340, while in the latter it was only 8,441, so that the deficiency in the latter period amounted to 899.

The Liverpool School of Tropical Diseases.

THE local financial support which is being accorded the Liverpool School of Tropical Diseases testifies very highly to the interest shown in the enterprise by the townspeople. The latest development in this direction is the endowment of a Colonial Fellowship in connection with the school, of the value of £100 per annum for five years. The Fellowship is for the purpose of mainly encouraging the study of tropical diseases among graduates of a colonial university.

Sanitary Work in Leeds.

THE public movement in favour of better standards of sanitation that has been carried on for some years past under the auspices of the Leeds Sanitary Aid Society is worthy of emulation in other parts of the United Kingdom. The Society has taken in hand the prevention of consumption, and anticipates the speedy establishment of a special sanatorium, a step that is highly desirable in a manufacturing district where phthisis is rife. Another important subject in which it has shown much interest is that of cremation, and, thanks to its persistent advocacy, the

Corporation has now under consideration a scheme for the founding of a crematorium. One of the speakers, Dr. Churton, at the recent annual meeting, made a statement that more than justified the existence of the society. Speaking of the excessively high death-rate in New Wortley and Hunslet, he asserted that the sanitary conditions of parts of those districts were as bad to-day as they were fifteen or twenty years ago, and in some respects even worse. The chairman, the Vicar of Leeds, made the interesting practical remark that the sanitary improvements which many members of the Corporation were anxious to introduce could scarcely be made unless there was a strong body of public opinion in their favour. That principle is one that may be impressed with advantage upon every medical officer of health at the outset of his career. While he may prompt, guide, and influence sanitary advances to the best of his power, it is nevertheless unwise to introduce matters that are far ahead of general information. A valuable field of work lies in the diffusion of knowledge on sanitary matters by the aid of lectures and pamphlets.

Malaria in Children.

THE study of the diseases of children derives an especial interest from the modifications that often take place in the clinical features even of well-marked maladies. In the adult a parallel instance may be found in the ambulant form of enteric fever, which is calculated to elude the grasp of the most skilled and observant medical attendant. In the malaria of children under five years of age there are certain peculiarities which all practitioners engaged in malarial regions will do well to bear carefully in mind. The first marked divergence consists in the mildness or absence of the first and the third stages, so that there may be neither cold nor sweating stages, but simply the hot or febrile intermediate condition. Then the hour of onset of the paroxysms may be irregular, a fact that would naturally mislead anyone accustomed to the clockwork punctuality of the attacks in grown up persons. Another disturbing factor in children is the marked tendency to nervous manifestations. On the other hand, enlargement of the spleen is constant, and of course in doubtful cases the diagnosis of malaria can be confirmed by the demonstration of the *plasmodium malarie* in the blood. It is not altogether surprising, when the difficulties of the position are recognised, to learn that malaria in children has been often mistaken for chronic intestinal dyspeptic troubles, tuberculosis, septic infection, and enteric fever. Considering the former prevalence of ague in the United Kingdom and the close connection with tropical countries it is not unlikely that a recognition of the foregoing facts would now and then throw a flood of light upon an otherwise obscure infantile sickness.

An Italian Congress on Tuberculosis will take place, under the patronage of the Queen of Italy, at Naples on April 25th, and three following days.

The Housemaid as Sanitarian.

THE recognition of the fact that the dust of our streets is charged with a fabulous number of micro-organisms, some of which at least are capable of producing disease in man, is likely to enhance the position of the housemaid as a domestic sanitarian. The chain of reasoning is simple. The roadways of towns are extensively contaminated by horse droppings, which contain countless hosts of bacteria, harmful and otherwise. In dry weather the passage of vehicles and air currents distribute this deadly material in a cloud that hangs far and wide like a heavy pall around our towns and cities. This dust penetrates into our larders, into the innermost recesses of our dwellings. If anyone question that fact let him put a good heavy book away in a cupboard in a town house and leave it there for six months. At the end of that time he will find the dust has settled here and there between the pages. The daily scavenging, so to speak, of household dust becomes at once elevated into a sanitary precaution of the first rank. The housemaid of the future will probably be educated on scientific principles. Instead of sweeping carpets she will be directed to rub them over with a damp cloth, if indeed such things as carpets be permitted in the future ideal sanitary house. All honour to the housemaid for her untiring zeal and thoroughness of purpose. At the same time it may be stated that, from a scientific point of view, the day of the dustpan and the domestic brush is gone, although it will certainly require several generations to revolutionise the deeply rooted household traditions in that direction.

Payments by Hospital Patients.

THE medical profession may congratulate itself upon the wide-spread interest taken in its affairs by outside philanthropists. These worthy gentlemen, as a class, are always ready to say what should, could, would, might, and ought to be done for the benefit not only of the profession but also of the rest of the community. If there be one single fallacious argument that has damaged medical practitioners more than any other it is the pernicious doctrine that hospital patients should pay partly or wholly for what should be charitable relief. The result of the pay system is to encourage those who can contribute a few pence to imagine they have a right to purchase advice and medicine from a medical charity, instead of going to a qualified medical man. The competition does not stop there, however, for by starting paying wards the hospitals take away from the profession patients who can afford to pay good fees. The general hospitals that to their unqualified disgrace exact pence from the poor are the London, Guy's, the Poplar and the Great Northern Hospitals; while St. Thomas's, Guy's and several others have paying wards. This system was greatly lauded last week by the Duke of Northumberland, whose chief argument appeared to be that there were many persons treated at hospitals who ought not to take advantage of charity in such directions. Quite so, but why does

not His Grace go to the root of the matter and exclude such improper applicants for relief instead of seeking to exact pence from them and thereby to lead them to imagine their false pretences are covered by a petty money contribution to the funds of the hospital?

The Midwives Question in Ireland.

As this precious Midwives Bill does not extend to Ireland or Scotland, neither of these divisions of the kingdom have thought it their business to take much notice of it. But Ireland is now face to face with the danger of its enactment there. For its imposition on Ireland there is not the faintest excuse, inasmuch as there can scarcely be said to be, in that country, a class of midwives analogous to those practising in England, and no one has asked for the embodiment of such a class. The only midwives in Ireland are those who serve under the Medical Officer in dispensary districts, and are paid out of the public funds. It is now sought to thrust into each such district one or more registered midwives to compete with the local Medical Officer, and from whom do our Irish readers think this benevolent suggestion comes? From the President and Fellows of the Royal College of Physicians in Ireland, who have always posed as the best friends of the profession, and the uncompromising foes of every invasion of their rights. That College has addressed the Irish M.P.s and the members of the Grand Committee entreating them to extend the measure to Ireland, and as far as can be judged from the communication, the College has taken this extraordinary course for the sake of its own forty-nine midwife licentiates, and for the sake of the women who have heretofore paid their money to the Rotunda and Coombe Lying-in Hospitals, which institutions are influentially represented among the Fellows of the College. A more audacious proposition has never been made in the interests of a more insignificant class, and we certainly expect that the leaders of professional opinion in Ireland and the licentiates of the College will make it clearly understood that their feelings and interests cannot be set at nought in this way.

Foreign Hospital Scandals.

MUCH excitement has been caused among the public in Vienna anent an action for libel brought by the medical staff of a private hospital for children against the author of a pamphlet containing statements which reflected very seriously on their skill and humanity. The trial lasted several days, and many dramatic scenes occurred during the hearing of the witnesses for the defence. Ultimately the jury found a verdict practically exonerating the libellers on the ground of justification, and the judges marked their sense of the case by ordering the plaintiffs to pay all costs. The case of Professor Neissner, of Berlin, has once more come to the front, consequent on an interpellation in Parliament. This eminent professor, on whose conduct we commented some months since, stands convicted of having carried out a series of inoculative experiments with syphilitic serum, to the

detriment, and without the assent, of the subjects, and it is highly probable that the authorities will be constrained to take disciplinary cognizance of such indefensible conduct. It is deeply to be regretted that professional men should allow their zeal for science to outrun their discretion, and lead them to ignore the elementary principles of humanity. By so doing they retard the progress of science, and give a handle to those who are disposed to criticise hospital management.

The Edinburgh War Hospital.

PROFESSOR JOHN CHIENE, who was invited to take charge of the Edinburgh Hospital for South Africa under the military co-operation of Sir James R. A. Clark, M.R.C.S., lately Surgeon-Major, A.M.S., left Edinburgh with his staff last week in a special train direct for Southampton to embark in the *Briton*, en route for the Cape. His own private assistant, Mr. David Wallace, one of the assistant surgeons in the Edinburgh Royal Infirmary, accompanied him as his second in command—a happy augury for the successful carrying out of the scheme; while Dr. Francis Boyd, who was appointed medical officer not long before the departure of the *personnel* of the hospital, represented the physician's side. The surgical, and medical, and nursing members of the staff, before leaving, attended a special service in St. Giles' Cathedral, and were inspected in the quadrangle of the University by the Commander-in-Chief in Scotland.

PERSONAL.

SIR FRANCIS R. CRUISE, M.D., has been appointed to be one of the Commissioners of National Education in Ireland.

DR. EDKINS has been appointed joint lecturer in physiology with Dr. Klein, at St. Bartholomew's Hospital Medical School.

MR. VICTOR HORSLEY is to deliver a lecture on "The Effect of Alcohol on the Human Brain," on the 27th inst. at St. James's Hall, Piccadilly.

SIR JAMES REID, Bart., K.C.B., M.D., Physician in Ordinary to the Queen, has been elected an honorary Fellow of the Royal College of Physicians of Ireland.

DR. ARTHUR A. MUSSEN has been appointed Assistant Medical Officer of Health for Liverpool, thus rendering vacant the post of Medical Officer of Health at Huddersfield.

IN the temporary absence of Sir Savile Crossley, Viscount Duncannon will discharge the duties of the honorary secretaries of the Prince of Wales' Fund for London.

PROFESSOR OSLER has telegraphed from Baltimore to the effect that there is no foundation for the statement that he is a candidate for the vacant Chair of Medicine in the University of Edinburgh.

PROFESSOR GRUBER, whose classic work on diseases of the ear is known to most specialists in that department

in this country, died suddenly in Vienna on Saturday last. He will be greatly missed by the many British and American students who attended his lectures in Vienna. His son, Dr. Rudolph Gruber, was in London at the time of his father's death and immediately returned to Vienna.

We announced last week that the Government had decided to appoint a Medical Registrar of Vital Statistics to assist Mr. Matheson, who is not a member of our profession, to fulfil the functions hitherto discharged by Dr. Grimshaw as the Registrar-General for Ireland. Dr. Ninian Falkiner, hitherto serving as Medical Officer of one of the Dublin districts, has been appointed, and the selection will be approved. Dr. Falkiner is an M.B. and M.Ch. of Dublin University, and has a considerable reputation as an authority on chemistry and on hygienic statistics. Besides that he is known to be energetic and industrious in all he undertakes.

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

VOICE PRODUCTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Twenty-seven years ago I had the honour to write a series of articles on the above subject in your journal, in which I tried to prove scientifically the accuracy and benefit of one specific mode of training, then almost lost, as contrasted with the prevailing methods. At that time little was taught that was true; now much is taught that is false.

In those articles it was shown that the musician's training is too contracted, and his sensuous art too strong a bias to enable such to be successful voice trainers, and I alleged that the work was properly the work of a musical surgeon with a trained voice. The reprint under the title of "The Philosophy of Voice," I dedicated to the members of the medical profession, in the hope that that profession would as a body—not as stray units—take the question up. It did not do so, and the success of my little work caused such a number of unqualified imitators that I feel like a modern Frankenstein who has launched not one but many monsters into space.

Let me point out what has, in my opinion, been the result of this reticence on the part of the medical profession.

The School Board was instituted in 1870, and for ten years we heard nothing of any of its teachers suffering from throat trouble. Since 1880 increasing complaints have been made at the spread of what is called "Board School Laryngitis," and in the *School Board Chronicle* for March 3rd last we are informed that there are in London alone 1,800 out of 3,000 teachers suffering from this complaint, more than half, in fact. It would be interesting to learn (1) who first invented the term, and when it first appeared; (2) is the increasing number of "voice producers" the cause of the increased disease, or are they concurrent events that have nothing to do with each other? The testimony of probability points to the fact that the false methods are responsible. But whether this be so or not we have the startling fact before us that last year the School Board engaged, at the ratepayers' expense, a number of lecturers and teachers holding diametrically opposite views.

Let me once more earnestly beg the profession for whom I had the privilege to write to make a searching inquiry into the subject while Manuel Garcia is still alive.

I am, Sir, yours truly,

CHARLES LUNN.

CONSULTANTS' FEES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your article which deals with the half-guinea fee of consultants, it would be interesting to know if many of the regular readers of your journal agree with you or not in the views you express. It has always appeared to me to be unreasonable for young consultants to be expected to get the same fees as those more advanced, and when we see among barristers a great variation in fees taken for work done, it certainly seems very unfair to make the young consultants work on for years till all get the same fees.

Among barristers, and in other professions whose individual character determines the value of the work they do, there is no such fixed scale of fees as among physicians and surgeons. Why one or two guineas should be the regular fee is not very clear. It may be to the advantage of the leading consultants to keep a fixed fee and exclude young consultants from sharing in any way in their business; but whether this is to the advantage, first, of the public, and next of the profession, is a question which, I think, has not been properly considered in your article, and I hope that you will reserve any opinion upon those that differ with you until we see how the Birmingham plans develop.

I am Sir, yours truly,

FREE TRADE.

EXTRAORDINARY RESULT OF A GUNSHOT WOUND.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The following remarkable gun-shot injury, reported by Dr. C. B. Johnston (*Ohio Den. Jour.*) may prove interesting to your readers. During the Inter-State War in North America, at the siege of Vicksburg, on June 10th, 1863, Captain A. Myatt, of the Confederate States Service, received a shot in the right eye; the missile afterwards proved to be a Springfield rifle ball, of about .55 calibre. The wounded soldier remained in hospital until the fall of Vicksburg, the 4th of July, 1863. General Grant, who was in command of the Federal forces, visited the Confederate hospital after the surrender, and had his attention called to the nature of the wound, and became so interested in the case that he ordered his staff surgeon to visit the patient and examine the wound. After careful examination this surgeon agreed fully with the diagnosis made by the Confederate surgeons that the bullet, after penetrating the eye, had taken a backward course lodging in the back part of the head, its location making its removal impossible, except at the risk of the patient's life. On July 17th the patient was paroled and sent home, a physical and, alas, a financial wreck. Notwithstanding his condition, however, he has since accumulated a competency for his declining years, and made ample provision for his family.

During these thirty-five years he suffered more or less constantly from the pressure of the bullet, and from time to time visited the most eminent surgeons in hope of obtaining relief, among others the noted Dr. Stone, New Orleans, but always to no purpose. His sufferings were finally brought to an end by the services of a dentist, and in a most remarkable manner.

In the Fall of 1898, Captain Myatt called on Dr. Johnston, Monroe, La., for the removal of a broken tooth. To the surprise of the operator, a foreign substance, evidently lead, was found to be occupying the depths of the socket after the removal of the tooth. This seemed so incredible that, at the request of the patient, his family physician was called in to make an examination. A brother dental surgeon, Mr. J. F. Johnston, was also called in. After careful examination the foreign substance was pronounced to be the bullet which had entered the eye of the patient thirty-five years previously.

The operation of removal was tedious and difficult, it was necessary with saws and drills to divide the bullet into sections, and several days were consumed in the operation, as the patient objected to the use of any anæsthetic.

It was successfully accomplished, however, and the old veteran enjoys life once more, and has gained twenty pounds in weight since the operation.

After removing the several pieces into which the bullet had been divided, the gaping wound was well washed out with peroxide of hydrogen, and packed with medicated cotton wool, the dressing being changed about once a week. Some little necrosed bone was thrown off, and there is still a little more, but as the patient will not permit the use of any anæsthetic, Mr. Johnston proposes simply to assist nature in completing the powers of healing. One small piece of necrosed bone came away through the nostril. The patient is doing well, and has better health, and enjoys life more than at any time since receiving the wound in 1863.

I am, Sir, yours truly,

GEORGE FOY.

Dublin, March 31st.

A SAD AND URGENT CASE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR.—The following subscriptions have been received since those last notified, and which now close the list, the total amount subscribed in response to Dr. Macnaughton-Jones's appeal being £110 5s. 6d.

The enclosed is the copy of receipt from the solicitor, who has kindly undertaken the further disbursement of the fund in weekly payments.

I am, Sir, yours truly,

WILLIAM H. BOURKE, M.D.

8, Moreton Gardens, South Kensington. S.W.,

March 28th, 1900.

"Received from Dr. W. H. Bourke, the Treasurer of this Fund, the sum of eighty-two pounds, nineteen shillings, and tenpence, being the balance in his hands (after certain urgent payments), to be applied by me, as arranged, for the benefit of the recipient and his family.

"HERBERT R. BLISS,
"Solicitor.

"Carlton Chambers, 8, Regent Street, S.W.,

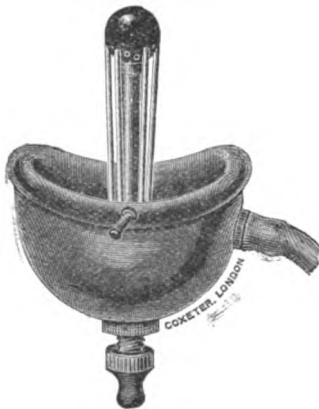
	£	s.	d.		£	s.	d.
Miss Corrie ...	1	1	0	Mrs. Tomkins ...	0	10	0
Dr. P. J. Freyer ...	1	1	0	Mrs. Jones ...	0	5	0
Dr. W. Roughton ...	1	0	0	Dr. A. Cosgrave ...	1	1	0
Sir Thos. Smith, Bart., F.R.C.S.	5	0	0	Total ...	£9	18	0

New Surgical Appliances.

NEW FORM OF VAGINAL DOUCHE TUBE.

DR. ALEXANDER DUKE, of Cheltenham, has devised a novel form of vaginal douche which offers certain advantages over those in general use. The flushing current being altogether from above downwards and the tube adjustable to the length of the vagina, while the walls of same are kept apart by stout incorrodable wires (surrounding central tube), the flushing is necessarily more

complete. The perforations at top of tube through which the fluid is forced, are so placed that they cannot possibly come into contact with vaginal walls (which of course would prevent exit of the fluid), nor are the openings at all likely to become plugged with any vaginal or uterine secretion when tube is being inserted, as is the case with most other vaginal douche tubes extant. These advantages, combined with improved form of



receptacle for waste (which has an inflatable rubber

edge), should make it both comfortable to patient and at the same time effectually prevent any wetting of the bed or person. The fluid collecting in receptacle (which is held in close proximity to vulva) finds exit through rubber tube attached, the end of which can be dropped into any convenient vessel. It can be attached to any rubber vaginal syringe as well as douche. The makers are Messrs. Coxeter and Sons, Grafton Street, London.

IMPROVED EAR DRUMS.

THIS invention, which is due to the ingenuity Mr. H. J. Dadysett, L.R.C.P., of Bombay, consists of a trumpet



and an ear drum combined in one. The whole instrument is made of india-rubber, so that the apparatus may be worn day and night without causing any pain in the ear as is done by harder

substances. In this ear drum the trumpet-shaped tube collects and assists the conduction of sound-waves to the natural tympanum which is not found in other ear drums, as of Toynbee's and Field's. In cases where by reason of perforation the tympanum has injuriously been permanently rendered useless, this invention is useful. The disc-shaped portion at one end of the trumpet-shaped tube is cut with scissors to the size of ear-canal and introduced into the ear so that it covers up the perforation and supplies the place of the natural tympanum, whilst the sound is gathered in the trumpet-shaped tube and conducted by the central wire into the middle ear.

In cases where there is a slight deafness due to dry catarrh, the central wire is omitted and the sound-waves are gathered and transmitted strongly by one trumpet-shaped tube alone to the middle ear. Another advantage of this invention is that it is so simple and easy of introduction that it can be done by one's own hand. Again, it is almost invisible when in use. These drums are manufactured by Arnold & Sons, West Smithfield, London.

Literature.

LARRIERU'S CURE PROMPTE ET RADICALE DE LA SYPHILIS. (a)

THE author of this interesting treatise asserts that his aim is to show that in most cases syphilis may be arrested from the very beginning, that the disease when it has reached the eruptive period can be definitely cured by a treatment of from four to eight months, during which time only an insignificant minimum of manifestations of the malady will be met with, and finally, that the disastrous effects of hereditary syphilis can be very much lessened, if not altogether prevented, and that a syphilitic woman, if only recently infected, can be ensured a natural pregnancy with confinement at term, even if the conception takes place at the period of infection or a short time afterwards. Our breath is so taken away by the magnitude of the assertion that we have barely sufficient left to ask how such magnificent results can be obtained: a glance into the book will furnish the answer: by taking in a little water from 3 to 5 minims of a recently prepared tincture of iodine every morning on an empty stomach, or 3 minims of the tincture in a tablespoonful of a solution containing 320 grains of crystallised sodium iodide in about 8 ozs. of water, this treatment to last for 20 days, and to be resumed once or twice if considered necessary, after intervals of from 10 to 15 days; at the same time the chancre is to be cauterised with Vienna paste. By means of this treatment the sore heals, any ganglionic enlargement disappears and, to use the words of the author, "we wait in vain for secondary symptoms." So much for what is regarded correctly or not in the work as the primary lesion of syphilis. Now for Dr. Larrieu's treatment of secondary

(a) "Cure prompte et radicale de la Syphilis, Syphilis et Mercure." Par le Dr. J. F. Larrieu. Pp. 131. 3rd Edition. Société d'Éditions Scientifiques, 1899.

symptoms which, from the above statement, he must evidently have only met with in patients who had not come under his care for the primary lesion. The treatment is precisely the same (tinct. of iodine in a solution of sodium iodide) excepting that it is to last five or eight months, with intervals (longer after the fourth month) of ten days in each month; white precipitate ointment to be applied to the cutaneous or mucous syphilides; however, in grave cases, where ocular or intestinal symptoms supervene, the author advises the temples of the patient to be occasionally anointed with blue ointment for five or ten days. With this treatment all symptoms, he asserts, disappear in from three to eight days. Three cases are cited in support of this; the two first are undoubtedly examples of secondaries, but the third is evidently one of tertiaries, which would naturally be benefited by the sodium iodide. Chap. V, is devoted to the consideration and treatment of syphilis in pregnancy. The author endeavours to prove not only that mercury is of no avail, but that it is absolutely noxious, inasmuch as it may cause premature expulsion of the fœtus, and he pins his faith on his treatment by tincture of iodine. The last chapter deals with hereditary syphilis of paternal origin. After referring to Colles's law and quoting largely Prof. A. Fournier, Dr. Larrien says: "In short the so-called hereditary syphilis is simply a congenital syphilis, it is naturally transmitted to the fœtus by the already infected mother." After reading this work with great interest we cannot bring ourselves to have implicit faith in all the author's dicta, but his treatment might, it seems to us, have some *raison d'être* in the treatment of secondary or tertiary syphilis, but we are very sceptical of its effects for the primary lesion.

Obituary.

DR. ST. GEORGE MIVART.

WE regret to announce the death of Dr. St. George Mivart, a well-known writer upon scientific matters. His works on comparative anatomy and other subjects were well known, but his chief mission was the reconciliation of scientific teaching with the dogmas of the Roman Catholic Church, of which he was a member. For some time past Dr. Mivart has stood almost alone in his position of an eminent scientific man who refused to accept the Darwinian doctrine of evolution. Latterly, however, one of his books was put in the Index, and he himself was later solemnly admonished and then banned by Cardinal Vaughan. Dr. Mivart's was a busy and distinguished life.

DR. R. H. GUNNING.

THE announcement of the death of Dr. R. H. Gunning, M.A., LL.D., M.D., a Grand Dignitary of the Empire of Brazil, and an old student of Edinburgh University, has been received in this country with great regret, especially in Edinburgh, whose fame he had enhanced by his successful career, and whose medical institutions he had enriched by the foundation of several valuable scholarships and prizes, mainly based upon patriotic feeling and in celebration of Queen Victoria's Jubilee of 1897. The Gunning Victoria Jubilee prizes in the University, and the Cullen Scholarship in the Royal College of Physicians of Edinburgh will long serve to perpetuate the name of one who had it in him to devote during his lifetime a large part of his means towards the advancement of that science of medicine which was so dear to his heart, and in which he himself won such success under what were often difficult and trying circumstances. His name deserves to be remembered as that of one who throughout the entire extent of a varied but ultimately successful career, successful, irrespective that is of actual performance of duty, for that always was beyond cavil, but in pecuniary reward, never forgot the mainspring which had end to it—a sound medical education—nor the importance of adding to the tale of prizes in medical schools, stimulating the application of students to their subjects.

PROFESSOR GRUBER, OF VIENNA.

THE death has been announced of Professor Josef Gruber, of Vienna, at the ripe age of 73. He was one of the early workers in the field of otology, in which he won a distinguished position. Two years ago he retired from his lectureship, owing to an age limit imposed in the University, after having lectured continuously on his subject for nearly forty years. He was a voluminous writer, and his anatomical and physiological studies on the auditory apparatus are well known, as also his standing treatise on otology. Among the students under him have been many hundreds of Englishmen and of Americans.

Medical News.

The Botany of Shamrock.

AT a meeting of the Royal Botanic Society at Regent's Park Gardens on March 24th the secretary called attention to the recent controversy as to what was the true shamrock. Sowerby, in his "English Botany," gave two plants, the *Trifolium repens* and the *Oxalis Acetosella*, both of which were spoken of as the true shamrock, and were usually regarded as such, while Dr. Prior, in his "Popular Names of Plants," gave *Medicago lupulina* and *Trifolium repens*. In Ireland the peasants went out on to the hillsides and pastures and gathered any species which happened to grow there, and regarded this as the true shamrock. The chairman (Mr. Brinsley Marlay) said there was no doubt that in Ireland it was *Trifolium repens* which was almost invariably said to be the shamrock, but it appeared to him that what St. Patrick, if he ever existed, held up was the *Oxalis Acetosella*, the leaves of which were far more distinct. The ordinary clover, however, had been used instead. He had never seen *Oxalis Acetosella* sent over from Ireland for use as the shamrock.

City of London Orthopædic Hospital.

AT the annual meeting of governors of this institution, held at the hospital, Hatton Garden, on Wednesday last, the forty-ninth annual report was presented, and the hope was earnestly expressed that as next year is the jubilee of the hospital, that the special efforts of the committee to release it from its large debt would be successful. The number both of out-patients and in-patients during the year had considerably increased, showing an appreciation by the deformed poor of the benefits they receive at this hospital, which is devoted entirely to their interests. The committee tendered their most hearty thanks to the honorary medical staff, viz., Messrs. Noble Smith, John Poland, Chisholm Williams, J. Jackson Clarke, Henry Davis, and F. W. Goodsall, and it was announced that Lord Mansfield had accepted the office of chairman of the committee of the hospital in place of the Earl of Aberdeen, resigned.

Outbreak of Anthrax.

A SERIOUS outbreak of anthrax is reported from Cumberland among a herd of pure bred shorthorns, several animals having succumbed to the disease.

A DRAFT of 160 men of the R.A.M.C. is to be prepared at Aldershot for embarkation for South Africa about April 6th. It will be composed entirely of specially enlisted St. John Ambulance men, 120 of whom will join at Aldershot to-morrow. Major Hassard, R.A.M.C., will go out in charge.

THE funeral of Dr. Dickson, who from 1856 to the day of his death had been physician to the British Embassy in Constantinople, took place on March 28th in the presence of Sir Nicholas O'Connor, the staff of the Embassy and Consulate, the members of the Board of Health, delegates representing the other Embassies and Legations, and many members of the British and American colonies in Constantinople.

DR. SHARPLES, L.R.C.P., M.F.C.S., a native of Preston, was found dead in his surgery at Castleton on Tuesday evening.

Notices to Correspondents, Short Letters, &c.

1st CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be pared by attention to this rule.

THE PROHIBITION OF STREET SPITTING

To the Editor of the MEDICAL PRESS AND CIRCULAR.

SIR,—The prohibition of spitting in the streets now about to be enacted by the Paris Municipal Council should stir up our own London County Council to consider a similar measure for the metropolis. We might expect an exemption to the rule, if made, for the district of Spitalfields, and inquire how the Salvation Army are to be controlled in this matter? Surely the County Council cannot possibly expect a rate themselves if a rule such as the United States and Paris are now adopting should be made.

I am, Sir, yours truly,

A. D.

DR. S. S.—The fashion of giving salicin in rice paper or wafers has been somewhat in vogue of late. It seems to be a rather unnecessary refinement, but certainly affords some interest to patients.

C. O. N.—The latest treatment for refractory corns is (says the *N. Y. Medical Record*) to remove them by the aid of the chisel and mallet. No detailed notes of cases thus treated are at present available.

ENGLISH VISITORS ON THE CONTINENT.

We have received inquiries from two correspondents, dating from Florence and San Remo respectively, who have read the "Continental Notes" of our special correspondent, and ask for further information, which we are pleased to give from personal knowledge. Visitors in Italy or on the Riviera slowly recovering from influenza or its sequences would do well to take Aix-les-Bains on their way homewards, and try the "cure" there. In addition to its charming situation and far-famed springs, Aix has the most modern therapeutic treatments, electrical, douches, Zander, &c. The "Aix Massage" is so esteemed, that Bath and other first-class Spas in our own country have adopted it. It has excellent physicians, and capital hotels. Personally, we can recommend the old-established and recently enlarged "Grand Hotel d'Aix" (near and on a level with the Baths and Casinos; also the homelike Hotel d'Albion, on the hill slope with fine prospect over lake and mountain. English visitors may rely upon having a cordial reception at the Savoy Spas of Aix. Brides, Challes, Uriage, &c., and, in fact, all through France.

Meetings of the Societies and Lectures.

WEDNESDAY, APRIL 4TH.

OBSTETRICAL SOCIETY OF LONDON.—8 p.m. Specimens will be shown by the President, Dr. W. Duncan, Dr. Cullingworth, Dr. Stabb, Dr. Addinell, Dr. Macnaughton-Jones, Dr. C. H. Roberts, Dr. Tate, and Dr. A. W. W. Lea. Papers: Dr. J. M. M. Kerr: Three Cases of Incarceration of the Retro-displaced Gravid Uterus and one of Extra-uterine Pregnancy simulating that condition.—The President (Mr. A. Doran): A Case of Extra-uterine Gestation in which Fœtal Death occurred at the Eighth Month after Spurious Labour, Abdominal Section two months later.

THURSDAY, APRIL 5TH.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Tichborne Street, Edgeware Road).—Discussion on Purulent Nasal Discharges and their Treatment (opened by Mr. E. Roughton.) Dr. D. Grant, Dr. W. Hill, Dr. H. Tilley, and others will take part.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.—5 p.m. Dr. W. B. Cheandle: Some Cirrhoses of the Liver. (Lumleian Lecture.)

FRIDAY, APRIL 6TH.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY (West London Hospital, Hammersmith, W.).—Papers:—Mr. F. Dunn: Purulent Ophthalmia and its Treatment.—Dr. H. Snow: Three Cases illustrating the Clinical Behaviour of Gall-stones.

LARYNGOLOGICAL SOCIETY OF LONDON (20, Hanover Square, W.).—5 p.m. Cases will be shown by Sir Felix Semon, Dr. Beale, Dr. St. Clair Thomson, Dr. W. Williams, Dr. Tilley, Dr. D. Grant, Mr. C. Symonds, Mr. Lake, and Mr. Waggett.

SOCIETY OF ANÆSTHETISTS (20, Hanover Square, W.).—8.30 p.m.—Paper:—Mr. E. Willett: The Administration of Anæsthetics to Young Children.

WEST KENT MEDICO-CHIRURGICAL SOCIETY (Royal Kent Dispensary, Greenwich Road, S.E.).—8.45 p.m. Discussion on the Midwives Registration Bill (introduced by Dr. F. S. Toogood).

Appointments.

BROADBENT, GEO., L.R.C.P., L.R.C.S.Ed., L.F.P.S.Glas., Medical Officer for the Maltby Sanitary District of the Rotherham Union.

CLARKE, ARTHUR EDWARD, M.B.Lond., M.R.C.S., L.R.C.P., House Physician to Guy's Hospital, London.

DAVIES, AUBREY H., B.A.Cantab., M.R.C.S., L.R.C.P., Assistant House Surgeon to Guy's Hospital, London.

DU-BRIDGE, H., M.R.C.S., L.R.C.P., Assistant House Surgeon to Guy's Hospital, London.

EDKINS, J. S., M.B.Cantab., a Joint Lecturer in Physiology at St. Bartholomew's Hospital Medical School, London.

EVANS, T., M.R.C.S., Senior Assistant Medical Officer for the Workhouse, Parish of St. Pancras, London.

EVELYN, W. A., M.D.Cantab., L.R.C.P.Lond., M.R.C.S., Honorary Physician to the York County Hospital.

FIRTH, C., M.D.Lond., F.R.C.S.Eng., Medical Officer for the Children's Homes of the Gravesend and Milton Union.

GAITSKELL, H. A., M.A., M.B., B.C.Cantab., House Surgeon to Guy's Hospital, London.

GOSTLING, G. W. M.B.Lond., Honorary Surgeon to the York County Hospital.

GRIFFITHS, C. A., F.R.C.S.Eng., L.R.C.P.Lond., Honorary Assistant Surgeon to the Cardiff Infirmary.

HILTON, C. T., B.S.Lond., Assistant House Surgeon, in the Surgery at Guy's Hospital, London.

HOPKIN, R., L.R.C.P.Lond., M.R.C.S., Medical Officer for the Second Sanitary District of the Llandoverly Union.

JONES, D. W., L.R.C.P., L.R.C.S.Ed., L.F.P.S.Glas., Medical Officer for the Rotherham Sanitary District of the Rotherham Union.

MACNAMARA, A. P., M.B., B.Ch.Dub., Medical Officer for the Shrivensham Sanitary District of the Faringdon Union.

MCMUrray, J., M.D.Irel. M.Ch., Medical Officer for the Kirkdale Branch Workhouses, Parish of Liverpool.

MARRIOTT, O., M.B.C.S., L.R.C.P., Assistant House Surgeon to Guy's Hospital, London.

NORTHCOTT, JOHN FORD, B.A.Cantab., M.R.C.S., L.R.C.P., Assistant House Physician to Guy's Hospital, London.

OSBORN, A. G., M.B.Lond., Assistant House Surgeon to Guy's Hospital, London.

PEARSON, H. A., L.R.C.P.Lond., L.R.C.G., L.R.C.S.Ed., Medical Officer for the Fifth Sanitary District of the Royston Union.

REYS, W., L., L.R.C.P.Lond., M.R.C.S., Medical Officer for the Aberdare Town Sanitary District of the Merthyr Tydfil Union.

ROBERTS, ARTHUR M., F.R.C.S.Edin., Aural Surgeon to the Royal Berkshire Hospital, Reading.

SHUFFLEBOTHAM, FRANK, M.A., M.B., B.C.Cantab., Assistant House Surgeon in the Surgery at Guy's Hospital, London.

STEWART, WALTER, G., M.B., B.S.Lond., Assistant House Physician to Guy's Hospital, London.

SYMMONS, HORATIO P., F.R.C.S.Edin., M.R.C.S., Consulting Surgeon to the Warneford Asylum, Oxford.

SYMPSON, E. MANSEL, M.A., M.D., B.C.Cantab., M.R.C.S., Medical Officer to Her Majesty's Prison, Lincoln, vice the late George Mitchison.

TAYLOR, J. G., B.A.Cantab., M.R.C.S., L.R.C.P., House Physician to Guy's Hospital, London.

TEES, J., L.R.C.P., L.R.C.S.Edin., Medical Officer for the Woolwich Sanitary District of the Woolwich Union.

WILKIN, LANCELOT, M.A.Cantab., M.R.C.S., L.R.C.P., House Surgeon to Guy's Hospital.

Vacancies.

Bath Royal United Hospital.—Resident Medical Officer for three years Salary £100 per annum, with board, lodging, and washing.

Clonmel District Lunatic Asylum.—Assistant Medical Officer. Salary £125 per annum, with £50 in cash in lieu of rations, furnished apartments, &c. Applications to Resident Medical Superintendent. (See Advt.)

County Asylum, Shrewsbury.—Junior Assistant Medical Officer. Salary £130, rising annually by £10 a year to £150, with board, lodging, and washing. No liquors.

Cumberland and Westmorland Asylum, Garlands, Carlisle.—Junior Assistant Medical Officer, unmarried. Salary £100 a year, with board and residence.

City of Dublin Hospital.—Resident Medical Officer. Application to Mr. G. Jameson Johnston, F.R.C.S.I., Hon. Sec. to the Medical Board. (See advt.)

Devon County Asylum, Exminster.—Third Assistant Medical Officer. Salary £120, rising to £150, with board, lodging &c.

Down (County) District Asylum, Downpatrick.—Assistant Medical Officer, unmarried. Salary £100 per annum, with furnished apartments, board, washing, and attendance. (See Advt.)

Loughborough and District Hospital and General Dispensary, Loughborough.—Resident House Surgeon. Salary £100 per annum, with furnished rooms, attendance, and board.

New Zealand Public Lunatic Asylums.—Two Assistant Medical Officers, unmarried. Salary £250, with board, lodging, and washing. Apply to the Agent-General for New Zealand, 13, Victoria Street, London, S.W.

Births.

GOODISSON-BOON.—On March 30th, at Brosley, Shropshire, the wife of J. Goodisson-Boon, L.R.C.P., L.R.C.S.I., of a son.

GOWRING.—On March 30th at the Knowle, Newport, Mon., the wife of B. W. N. Gowing, M.R.C.S., of a son.

Marriages.

MAW—TINDALL.—On March 27th at All Saints' Church, Clipston, Henry, eldest son of William H. Maw, of Addison Road, Kensington, and Outwood, Surrey, to Agnes Dora, eldest daughter of A. McIvor Tindall, M.R.C.S., of Market Harborough.

Deaths.

BAYLEY.—On March 23rd, at Priory Cottage, Northampton, Cecil Bayley, L.R.C.S., L.R.C.P.Edin., aged 31 years.

FYFE.—On March 26th, at Ealing, Andrew Fyfe, M.D., F.R.C.S. Edin., aged 72 years.

MACDONALD.—On Feb. 16th, suddenly, at Salina Cruz, Mexico, A. M. Gillies Macdonald, M.B., C.M., son of the late R. H. Macdonald, of Glasgow.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXX.

WEDNESDAY, APRIL 11, 1900.

No. 15.

Original Communications.

COMPLICATED CASE OF DOUBLE OVARIOTOMY IN A GIRL, ÆT. 18 .

By J. HALLIDAY CROOM, M.D., F.R.C.S.E.,
F.R.C.P.E.,

Consulting Physician, Royal Maternity Hospital; Gynaecologist,
Royal Infirmary, Edinburgh.

G. S., ÆT. 18 , was first admitted to Ward 28 in the hospital, July, 1897, complaining of a swelling of the abdomen which had been noticed for sixteen months. The patient had never menstruated, but stated that at the age of fifteen she had some swelling of the abdomen which, however, gradually disappeared. Before admission the abdomen was tapped three times, on May 1st, June 10th, and July 15th. She had never complained of pain till a few days before she came into hospital. On admission the patient was very anæmic, and her face, neck, and chest were much emaciated, the abdomen was enormously distended, and her lower extremities were very œdematous.

Examination of the chest revealed the fact that the right pleural cavity was full of fluid, and the apex of the heart was found in the left axilla.

The surface of the abdomen showed the presence of numerous distended veins and many recent striæ, while the umbilicus markedly protruded. The note on percussion was absolutely dull in every part, while fluctuation was easily determined. The girth of the abdomen at the level of the umbilicus was 40 ins.

A few days after admission the right pleura was tapped, and 144 ozs. of blood-stained serum were removed, and a few days later still 280 ozs. of pinkish coloured fluid were aspirated from the abdomen. Thereafter, on examination, the presence of a large tumour, occupying chiefly the left and lower parts of the abdominal cavity, was made out. It was very hard, irregular in shape, and presented all the features of a malignant ovarian tumour, and, as such, it was then diagnosed, and the condition was considered a hopeless one. From July, 1897, till April, 1898, the patient lay in the ward, extremely exhausted and emaciated, although she never seemed to get specially worse. Exploratory incision, far less any attempt at operation, was not thought of, and, as a matter of temporary relief, her abdomen was tapped regularly once a fortnight and fluid removed, varying in quantity from 300 to 500 ozs. Examination of the fluid showed that it was mainly ascitic.

The right pleural cavity was also tapped during this period on four occasions, each time from 100 to 120 ozs. being removed. The œdema of the lower limbs was also frequently relieved by Southey's tubes. Gradually one was forced to the conclusion that, since the patient's general condition had become really no worse than on admission, and since the condition in the abdomen had not changed in any way, the tumour might not, after all, be malignant, and therefore it was decided that the abdomen should be

opened, and, if possible, the tumour be removed. Accordingly, on April 5th, 1898, I operated and removed one of the largest dermoid ovarian tumours I have met with. It weighed, even after tapping, about 30 lbs. It had developed from the left ovary, and the operation was comparatively simple, the pedicle being well defined, and the adhesions few and easily separated. The right ovary, which was apparently healthy, was left intact. After the operation the patient was extremely collapsed, but with free stimulation she speedily revived and made an excellent recovery. The œdema entirely disappeared, and the extensive general emaciation became more and more striking, but in the course of a few weeks the patient put on flesh rapidly, and by June 7th, was sufficiently well to be sent to the convalescent house, and a fortnight later she left for her home in Shetland.

She was re-admitted to Ward 28 on September 30th, 1899, when she appeared a tall, stout, well-built, healthy-looking girl. She had menstruated regularly since the last operation. She complained of a swelling of the abdomen which she had noticed for six weeks before admission. Examination of the abdomen revealed a large hard tumour occupying the middle line, and growing upwards, especially towards the right side, so that the dullness was almost continuous with that of the liver.

The diagnosis was that probably this was an ovarian tumour occurring in the ovary which had been left. On November 7th the abdomen was opened by an incision a little to the right of the previous cicatrix, and this, before the operation was completed had to be extended well above the umbilicus. The tumour which came into view was cystic, and on puncturing it a large quantity of brownish fluid escaped. The wall in some parts was very thick, and consisted largely of soft fatty looking, friable, lobulated tissue, which crumbled away when taken hold of either by the fingers or by forceps.

There were several adhesions, and at one part the tumour was intimately adherent to the small intestine, so much so that they could not be safely separated, and a piece of tumour wall about four inches by two was left adherent to the intestine after having been trimmed with scissors.

The pedicle, which was very broad, was secured by two ligatures, and the peritoneal cavity was thoroughly washed out. A drainage tube was inserted, the wound closed, and the patient put back to bed. She was extremely collapsed, and all the afternoon had great pain, and was inclined to be very restless. She was very cyanosed, and the pulse was small, thready and very weak. Brandy enemata and other stimulants were given. The tube was removed the next evening, and she gradually improved. The stitches were taken out on the sixth evening. Later a dry dressing was put on, and on the 23rd, three weeks from the date of operation the patient was up and looking perfectly well.

The microscopical examination of the tumour showed that it was a simple cystic papilloma.

This case seems to me to present many interesting features, but probably its chief importance lies in, first of all, the difficulty of diagnosis when the patient was first seen. The patient was admitted presenting every possible sign of abdominal cancer except her age, which, of course, is not of itself preventive, and it was only after she had laid in the ward and had been treated by palliative measures that the abdomen was opened. It must be extremely rare indeed to remove stained fluid from the pleura which is not associated with malignant disease. As far as I am personally concerned, I have not seen a case before.

This is quite in keeping with one's previous experience and suggests that in all cases where there is room for the least element of doubt an exploratory incision should be made. And yet how very much oftener on so opening the abdomen is one met with disappointment and with the fact that the condition is hopeless. The case also raises the question of the removal of the other ovary at the time of the first operation. In this particular case I have no regrets, for on the first occasion the other ovary was most carefully examined and seemed perfectly healthy, and therefore, especially as the patient was only 19 years of age, it was left intact. Indeed, even though there had been evidence of commencing cystic disease I think I should have been tempted if not to leave it entirely alone, at most to remove if possible only the part of the organ affected. I admit it is a difficult matter to tell whether an ovary is really diseased or not, because the perfectly functioning organs present such differences of appearance, but in this case, at all events, the ovary seemed to be perfectly healthy, and therefore was left.

Another point is that where there are extensive adhesions to the bowel, as in this case, and especially where the adhesions are very intimate, it seems to me safer and better to leave portions of the tumour adherent to the bowel, than to peel it off and leave large bleeding surfaces, or to have perforations which require to be dealt with carefully, and prolong the operation.

A CASE OF RUPTURE OF THE QUADRICEPS TENDON : PRIMARY SUTURE.

By ARTHUR H. BURGESS, F.R.C.S. Eng.,
M.B., M.Sc. (Vict.),

Resident Surgical Officer, Manchester Royal Infirmary.

W. B.—, *et. 58*, a railway guard, was following his usual occupation on the evening of August 15th, 1899, when, while entering his van as the train was leaving a station, he slipped and fell forward across its floor, his left foot being caught between the step and the platform. By a violent effort he wrenched his foot free and managed to scramble into his van, but found that he had severely injured his left knee in doing so. At the next station he was carried to a waiting-room, and a doctor was called to see him, who advised his immediate removal to this infirmary.

On admission here the left knee was considerably swollen and evidently contained a large quantity of effused blood. The patella was intact, but just above its upper border a deep gap could be felt in the quadriceps muscle about two inches in length. There was no power of extension at the knee joint, and on attempting it the gap in the muscle was increased to four inches.

Shortly after admission ether was administered, and the following operation carried out under strict antiseptic precautions. An incision four inches in length was made in the long axis of the limb extending upwards from the centre of the patella. On

dividing the skin and fascia, and exposing the upper border of the patella it was found that the quadriceps tendon had been torn off exactly at its insertion into the patella, the rent extending for some distance into the lateral ligaments of the knee on either side, so that the joint was laid widely open. After removing as far as possible all the effused blood from the joint cavity, the quadriceps tendon was drawn down and sutured to the patella by three stout silk sutures, each one passing obliquely through its upper border so as to avoid the cartilaginous surface, and then through the quadriceps tendon half-an-inch from its tora surface. By retracting the margins of the wound first to one side and then to the other, the torn lateral ligaments were approximated by four silk sutures on either side. Before finally tying the three central sutures the joint was well syringed out, first with perchloride, one in 2,000, and afterwards with boracic lotion. The wound was closed with silk without drainage, a dry dressing applied and bandaged firmly on so as to exert a uniform elastic pressure, and the limb maintained at rest upon a back-splint.

The course of the case was extremely satisfactory, the wound healing primarily, and all sutures being removed on the twelfth day. Slight passive movements were commenced on the nineteenth day, and continued each day afterwards; on the twenty-seventh day the patient was allowed to sit up in a wheel-chair, two days later he was permitted to use crutches, and a fortnight later he was discharged, walking out with the aid of a stick.

Five weeks afterwards he presented himself for examination, he could easily walk without any support, could flex his knee to a right angle and extend it perfectly. I again saw him two months later, when he expressed the opinion that his knee was practically the same as before the accident.

Maydl has recently shown that this accident is not so rare as was formerly supposed. He collected 221 reported cases of rupture of muscles and tendons, and of these 61 were of the quadriceps extensor or its tendon.

At the moment of rupture the muscle is in a state of sudden and violent contraction, so that it is not at all surprising to find that usually there exists a wide interval between the torn surfaces, and that the lateral ligaments of the joint are extensively lacerated. Generally the rupture takes place a little above the insertion into the patella, and not, as in the present case, exactly in that situation; the higher the rupture the less chance is there of any extensive opening up of the knee-joint.

Non-operative treatment by means of various mechanical appliances, such as are used in the case of a transverse fracture of the patella, is not likely to yield a good result, since, owing to the marked retraction of the injured muscle and the great difficulty in obtaining a firm purchase upon it, it is impossible to secure anything like accurate apposition of the torn surfaces. Unless, therefore, there are conditions present which negative the performance of any operation at all, every case of complete rupture of the quadriceps tendon ought to be treated by open incision and suture under strict antiseptic precautions. It is only when such precautions cannot be satisfactorily carried out that the operation involves any serious risk. Possibly the risk might be diminished by postponing operative interference for some six or seven days, until the inflammation consequent upon the injury has commenced to subside, such as has frequently been done of late in the analogous case of fracture of the patella. As regards the direction of the incision, I found with the longitudinal one some difficulty in suturing the extremities of the rents in the lateral ligaments, and in a future case I should be inclined to adopt a transverse incision. The central

sutures should pass below through the upper border of the patella, so as to obtain a firm hold on the bone, and if they are passed obliquely, the articular surface can be avoided, and no interference with the function of the patella will result. In all cases the tears in the lateral ligaments should be sutured, and the joint-cavity thoroughly cleansed from blood-clot. Drainage is unnecessary if all hæmorrhage has been arrested. Gentle passive movements may be commenced about the third week.

For permission to publish the above case, I am indebted to Mr. Joseph Collier, for whom I was acting at the time.

ON

OBSTRUCTIVE DYSMENORRHEA.

By ALEXANDER DUKE,

Cheltenham.

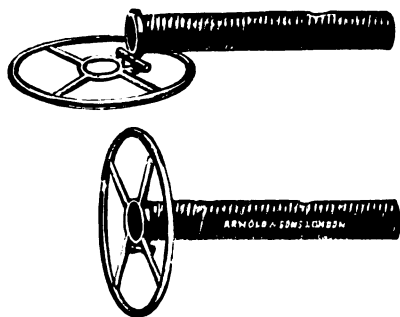
WHATEVER differences may exist in the professional mind with regard to the treatment of this distressing and painful complaint, I venture to affirm that mechanical treatment has so far given the best results.

Even in cases depending mainly on flexion, relief is afforded by dilatation or cutting. But to ensure permanent relief the cervical canal must be kept open, and the uterus, as much as possible, in the normal position.

The earlier the obstruction is recognised and treated the better. (As I have lately noticed a considerable enlargement of the uterine body in cases treated for years by drugs alone, evidently due to the long continued efforts of that organ to expel the menstrual secretion giving rise to hypertrophy, and in some cases producing flexion in addition.)

I have now treated a considerable number of inveterate cases by either gradual or forcible dilatation, and in some cases by the cutting operation of Sims followed directly in *all* by the introduction of my "spiral wire stem" to be worn by patient when up and about for at least three months, by which time (as a rule) the stem becomes loose, and can be removed, ensuring a patency of the canal unobtainable by any other means with which I am acquainted.

This appliance, designed by me several years since for the permanent cure of stenosis, has given me excellent results, and I have no hesitation in recommending its universal adoption in all cases of this nature.



I may claim for my stem it can be worn with comfort. No necessity for recumbent position except for first week at most after introduction. No vaginal aid required for its retention; its flexibility and hinged disc at base keeping it in position (see illustration). Several patients of mine have worn the appliance for months, one or two for over a year, and others while regularly riding the bicycle, quite unconscious of its presence (which I do not think could be said of any other form of uterine stem with which I am acquainted).

The instrument, of course, requires to be seen to now and then, as it may chance to get stopped by secretion, when one of its great advantages, *i.e.*, acting as a drainage tube, would be lost.

It is easily cleared by the "sound" or sinus syringe, but if the wearer follows directions, and uses the vaginal syringe or douche regularly every morning on rising from bed (the "period" included) there should be no trouble whatever.

The frequent failures resulting after treatment by cutting or dilatation alone were, of course, due (as I have often observed) to the subsequent contraction of the cervical canal or inner "os," making matters quite as bad as ever, and by its disheartening effect on the patient prevented her from seeking further advice or making any effort to obtain a lasting cure.

My stem has been modified more than once, but the illustration represents my latest pattern, and I make bold to say no other form that I know of can be worn for months with such comfort and manifest advantage. The makers are Messrs. Arnold and Sons, London.

The Tettisomian Lectures.

PRACTICAL OBSERVATIONS

ON

CANCER OF THE BREAST. (a)

By Sir WILLIAM M. BANKS, LL.D., F.R.C.S.,

Surgeon to the Liverpool Royal Infirmary; Emeritus Professor of Anatomy in University College, Liverpool.

LECTURE III. - (Concluded).

OPERATIVE PROCEDURES IN MAMMARY CANCER.

When I left my medical school in 1862, my recollection of operations for cancer of the breast was that they consisted of local removals of the tumour of the most imperfect description. If any glands were affected, not merely in the case of breast cancer, but in all instances, *ipso facto*, that was a sufficient bar to any operation. In 1867 Mr. Moore, of the Middlesex Hospital, whose experience of cancer in that institution was great, wrote what is now an almost historic paper on "Inadequate Operations in Cancer," which set a great many minds thinking, inasmuch as it was a revolt against constituted authority. It made me think too, so that I became deeply interested in the question. I hope that in what I am about to say I may not appear to be too self-satisfied with what little share I have been enabled to take in it. But this does seem an opportune occasion for presenting to the general public a review of the history of the operations for mammary cancer, seeing that the changes that have occurred in a very brief period have been of profound moment, and what has been done only a few years ago seems wonderfully soon forgotten. Well, then, during the ten years following Mr. Moore's protest great progress was made by the persevering and bold manner in which Lister and Bryant and Annandale and Heath and other able surgeons attacked secondary glandular growths, and demonstrated that all that was required for their safe removal was careful, patient dissection. Among English-speaking surgeons, Samuel Gross, of Philadelphia, was the next who made a notable move in favour of the free removal of breast cancers (Tumours of the Breast, 1880), and to him much is due for the earnestness and enthusiasm with which he pushed his cause; as will be remembered by all those who, like myself, had the privilege of being his friend.

My first paper on the subject was read to the Lancashire and Cheshire Branch of the British Medical Association in 1877, and was termed "A Plea for the more free Removal of Cancerous Growths." In it I said

(a) Delivered before the Medical Society of London, Monday April 2nd, 1900.

"I can point to several cases of hard scirrhus of the breast in which the whole mamma has been removed, which have now remained well for years. There is no mystery about this; all that is required is to take the precaution to cut freely through sound textures. *But this is exactly what surgeons will not do.* I have over and over again watched a surgeon remove a breast, and have seen him make his incision so as to include a little elliptical bit of skin containing the nipple, after which he would proceed to scoop out the breast so as to get nice flaps, which fell easily together and covered in the wound. He never considered that in the brawny dotted skin over the tumour were already implanted the germs of the disease, and that the most dangerous thing he could do was to leave plenty of skin, one of the tissues above all others along which cancer cells love to make their way. I can safely affirm that in the great majority of operations for cancer which I have seen, and they are not a few, the cancer has not been removed root and branch. When the tumour has been carefully looked at, after the excitement of the operation has been over, there has generally been found some spot where everyone wished that a bit more had been taken away. Not long ago I was looking over some old illuminated manuscripts. Among other pictures of the tortures inflicted upon the faithful there was one in which a horrid wretch was represented with a great crooked knife mangling the body of a devout female. He had slashed off one breast, the former site of which was represented by a great bleeding chasm, while with one hand he was clutching the remaining organ and with the other was preparing with one sweep to lop it off also. I could not help wishing that I had this picture to hang up in the students' room in our school; not in *errorem*, but as my idea of what most amputations of the breast ought to be; not a niggling, half-and-half digging out of the tumour, but a radical sweeping away of the whole mamma, skin and all.—I have a very strong notion that it would not be a bad plan when removing a breast always to clear out the axillary glands, whether we can feel anything wrong with them or not; and I mean to try it. At present we only remove the glands when we can distinctly feel them enlarged, and that frequently through a great deal of fat and a thick skin. How do we know they are not already affected? And then the patient disappears and doesn't return till the axilla is full and the great vessels are so mixed up with the disease that we despair about being able to clear everything out and so leave her alone. By disabusing the lay mind of the unreasonable dread of operation, the public will come to regard an operation for cancer in the same light as they do an operation for stone or for cataract; a bad job at the best, they will say, but still with a prospect of ultimate cure. They will come to us when their cancers are small and request us to remove them, and, if we could only extirpate them freely, what might we not expect? Have you ever imagined what the results would be if all cancers were thoroughly excised when they were no bigger than peas?"

Twenty-three years have elapsed since I said the above words, and I have very little more to say now.

In 1880—three years after the above appeared—appeared Mr. Samuel W. Gross' admirable work on "Tumours of the Mammary Gland." In it occur the following sentences:—"This point demonstrates that the wiser course is to explore the axilla, even if its glands cannot be detected from without. By clearing out that cavity in all operations we may naturally expect to diminish, if not prevent, further local dissemination, and remove foci of general infection." To Gross much is due for the earnestness and enthusiasm with which he pushed his cause, as will be remembered by all those who, like myself, had the privilege of being his friend.

My next papers were read before the meeting of the British Medical Association in Worcester in August, 1882 ("On Free Removal of Mammary Cancer with Extirpation of the Axillary Glands as a Necessary Accompaniment") and to the Medical Society of Liverpool in the same year. They are in purport the same paper. The results of 46 cases were given. May I quote a paragraph or two from it? I said,

referring to my paper written in 1877:—"In this paper it was asserted that surgeons do not remove cancers of the breast. After an interval of five years I feel obliged to reassert the statement. Surgeons, as a rule, do not remove cancers of the breast. They persuade their patients that they do, and they almost persuade themselves. But there is always that little bit which they leave behind, and which they fondly hope will not grow, because it is such a little bit. Alas! that a little leaven should leaven the whole lump!" "In the present paper a principal object is to advocate the removal of the axillary glands as well as the breast, in *all* cases, whether we can feel them enlarged or not—in fact, to make a clearing out of the axilla a necessary part of the operation for removal of the breast. I have been quietly practising this for three or four years, having been driven to the conclusion that it was the right thing to do by discovering that, even in those cases where certain glands could distinctly be felt enlarged when the axilla was opened small ones were discovered which although most palpably affected, were quite incapable of being affected from the outside. From this it follows that the usual fumbling in the axilla which is commonly practised is all nonsense. When the glands are as big as walnuts any first year student can tell that they are affected. But what I wish with all earnestness to insist upon is that there is a stage—the earliest stage—when they are certainly infected, although to the touch through layers of fat and skin, nothing amiss can be felt. When a dresser at the end of his report upon a case of mammary scirrhus, winds up with the stock phrase, 'Glands in the axilla not affected,' I immediately stop him with 'How do you know?' All that you should say is that you can't feel them, which is a totally different matter."

In 1887 I read a paper to the Harveian Society of London entitled "Extirpation of the Axillary Glands a Necessary Accompaniment of Removal of the Breast for Cancer," with details of eighty-two. I there reiterated the points I have just alluded to, and added some others which had struck me. "Having cleared out the breast, I do not cut it adrift, but leave it suspended by its upper and outer end. I next open the axilla, and in so doing carry away a continuous mass of tissue upwards from the mamma, with the object of including in it all the lymphatic vessels going from the breast to the glands. This is an important step, and should never be neglected." "I have tied the axillary vein at least half a dozen times, and there was not the slightest difference afterwards between these cases and others, so that it seems certain that careful ligation thereof is not in the least a dangerous proceeding. Is it necessary to divide the pectoralis major? Very seldom, I think. I imagine that out of my eighty-two recorded cases it was not done more than two or three times. If the floor of the axilla has been widely opened, and if the arm is properly drawn up you can feel with your finger quite well up to the clavicle and pinch or pull down glands from the very top of the cavity. Dividing the pectoral muscle adds somewhat to the tediousness of the operation but that is all."

Seeing that my paper, although urging the employment of a much more extensive operation than that usually performed, did nevertheless seem to prove that greater immunity from recurrent disease was obtained thereby, I had hoped to have received some little encouragement from the London surgeons present at the meeting. Exactly the reverse was the case. In the *International Journal of the Medical Sciences* (1888) is a most important paper by Mr. Samuel Gross, in which he said, "In the remarks on Banks' paper at the Harveian Society in the Spring of 1887, in which that surgeon reported eighty-two cases of extirpation of the breast along with the axillary contents, Bryant and Butlin questioned whether the complete operation afforded better results than the incomplete, and Butlin, Pick, and Cripps held that clearing out the axilla in every case was neither necessary nor judicious, although Pick asserted that the skin should be freely removed. Owen was the only member who gave cordial support to the procedure urged by Banks, the prevailing opinion being that the operation was attended with an excessive mortality,

and did not lessen the risk of recurrence." Mr. Thomas Smith, by the way, thought that the patients lived longest who had never been operated upon, and that it was a question for consideration whether a local excision of cancer did not render patients less liable to constitutional disease. I returned to Liverpool very much downcast after this meeting, but I am glad to think that after thirteen years Mr. Edmund Owen and I are here to-night to rejoice in the complete triumph of the principles for which we contended on the night of March 3rd, 1887.

MR. BUTLIN'S VIEWS.

"Before I enter on the discussion of this question let me say that no personal feeling exists between myself and those who hold the doctrine of extensive operation, and that, if I speak at any time warmly on the points under discussion, it is because the subject is one in which I take the warmest interest, and on which I hold very decided opinions. I entertain a great respect for both Dr. Gross and Mr. Banks, and only mention their names as the distinguished leaders of a school of surgery from which I venture to disagree." Mr. Butlin was good enough to make these very kind remarks in 1887, and I would like here entirely to reciprocate them. After this very generous introduction, however, he made some criticisms, which I am sure he will forgive me reproducing here, along with some remarks made in 1881 and 1898.

1881. *From the Transactions of the International Medical Congress.*—Mr. Butlin said that he quite agreed with Dr. Gross that in the case of any tumour of suspicious character the sooner it was removed, and the more freely it was removed the greater were the prospects of complete recovery, and, further, he agreed thoroughly with Dr. Gross that in the case of carcinomatous tumours it was highly desirable to extend the operation so as to examine the axilla, if there were any doubtful fulness, even though no definite enlargement the glands could be detected.

1887. *From "The Operative Surgery of Malignant Disease."*—Mr. Butlin wrote that no prolonged search need be made for the lymphatic vessels lying between the breast and the axillary glands. If there were not any distinct cords to be felt running up into the axilla, it was not necessary to search for the lines of lymphatic vessels, or to remove a large quantity of the fat and other tissues in order to insure their removal. Referring to Gross and Banks, these surgeons were in the habit of cutting off the mamma with all the skin which covers it, dissecting off the fascia from the pectoral muscle, searching for outlying lobules of the gland in the surrounding tissues, carrying the incision into the axilla, whether enlarged glands were previously felt there or not, and clearing out the glands and all easily removable structures. Both surgeons were impressed with the absolute necessity of very extensive operations if the patient was to be afforded a reasonable chance of complete recovery from the disease. Both surgeons had pushed this teaching so far that it had already gained many adherents, although he believed rather among foreign than among English surgeons. Indeed he was surprised to find how strong an opinion was expressed against it by some of the English operating surgeons at a recent meeting of the Harveian Society in the discussion of a paper by Mr. Banks. As he entirely disapproved of this wholesale way of treating cancers of the breast, and believed it to be unscientific and needlessly cruel to many women, he would venture to criticise it as thoroughly as he could. The operation recommended by Banks was not such an operation as that which was frequently practised in London and provincial hospitals, but was much more sweeping, for it included the whole of the skin over the breast and not merely over the tumour. In fact the breast was, so to speak, lopped off as if the operation had been performed with a sword or a carving knife. Now, he quite admitted that if the entire breast was to be removed in every instance of cancer, the operation should be of this sweeping character. But he was strongly of opinion that the practice of removing the whole of the breast in every case

was theoretically and practically wrong. Probably a long time and much false reasoning were required to induce the acceptance of the doctrine of the necessity of the removal of the mamma for cancers of small size limited to a part of it, and he was afraid a still longer time and much good reasoning would be required to convince surgeons that the practice was radically wrong. So far as the removal of the glands was concerned, by all means let them be removed when they can be felt enlarged and appear to be within reach of removal, and in cases in which there was a doubtful fulness which was not apparent on the other side. But let no theoretical considerations lead them further than this, and on no account let the axilla be opened in search of diseased glands of the existence of which there was not the least outward or palpable sign. In reply to all the arguments he had brought forward, Mr. Banks had at his command a very strong answer, viz., his results. He quite admitted, and with very great pleasure admitted, that, so far as his later results were concerned, they were the best he had ever seen from operations performed with the knife. The superiority of these statistics may be accounted for, not by the fact that the entire breast was removed in every instance, but because Mr. Banks was in the habit of sweeping away the disease itself and the surrounding textures in a fashion at which most operators would be horrified.

1898.—In the number of the *British Medical Journal* for November 26th, 1898, Mr. Butlin wrote that he had read Professor Halsted's paper on the "Results of Operations for the Cure of Cancer of the Breast" (1894), and his results appeared to him to justify a thorough reconsideration of the subject of the operative surgery of cancer of the breast. This operation was suggested by a paper in "Langebeck's Archive" (1888) on the causes of local recurrence of cancer after amputation by Dr. Heidenhain, and studied it along with a paper on the surgical anatomy of the breast and lymphatic glands reprinted from the *Edinburgh Medical Journal* (1892), which the author, Dr. Harold Stiles, had been so kind as to send him. Both authors had come to the conclusion, from a general and microscopical examination of a number of breasts which had been removed that cancer of the breast rapidly extends back towards and then into the pectoral fascia, even when there appears to the naked eye to be a considerable interval between the posterior border of the tumour, and that the pectoral fascia is often very difficult to separate satisfactorily from the surface of the muscle. Looking back on his own clinical experience in order to see how far it seemed to be consistent with the investigations of Heidenhain and Stiles he could quickly remember several cases in which recurrence had taken place in the substance of the pectoral muscle, after the removal of a cancer which appeared to be quite separate from the pectoral fascia, and even after the fascia had been roughly dissected off. (Then followed a long description of Halsted's operation with Mr. Butlin's expressions of belief in its value.)

Now, if any gentleman will take the trouble to turn up Mr. Butlin's work on "The Operative Surgery of Malignant Disease" he will find that the last chapter is devoted very largely to three things: (1) A subdued admiration of a certain Dr. Bougard of Brussels, who used caustic paste for the destruction of cancerous mammae as well as of the axillary glands down to the vicinity of the main vessels and nerves. (2) An advocacy of the mere removal of malignant tumours of the breast and nothing more, seeing that the evidence for the removal of the entire breast was only very partially true, and (3) a very sharp attack upon the doctrines then being promulgated by Dr. Gross and myself. Dr. Gross presently wrote these words "Had so good a pathologist as Butlin been in possession of the facts derived from my practice and that of Kuester he would scarcely have given utterance to so pernicious a doctrine—a doctrine which we fear will so influence English surgeons as to counteract in great measure the recent advances that have been made in the treatment of carcinoma of the breast."

For myself I offer no criticism. I have merely quoted the *ipissima verba* of Mr. Butlin in 1881, 1887

and 1898, and leave them to the consideration of the surgical profession.

HALSTED'S AND OTHER OPERATIONS.

In the *British Medical Journal*, December 8th, 1893, is a very full description of Halsted's operation. It contains fifteen photographs, with very minute details down to the grasping of the tumour with the left hand and the scrupulous dissection of the axilla with "the sharpest possible knife." The only points of any fundamental importance in which it differs from the operation ascribed by Mr. Butlin to myself (just quoted) consist in the removal of the sternal portion of the pectoralis major, and the division of the pectoralis minor with reflection of that muscle. This is described as necessary for the complete removal of the glands in the axilla. I desire entirely to dissent from this view. I do not believe it necessary—still less that the entire pectoralis major need be removed, as it is now Dr. Halsted's present contention. If the tumour be properly manipulated, and the great pectoral well dragged upwards and inwards, the very topmost point of the axilla can be cleaned out. Moreover, if there is any doubt at all, the great pectoral muscle can be cut across with very little trouble, and then stitched together with catgut sutures, as I have even now and then done. In the Transactions of the American Surgical Association, Dr. Halsted relates that he now almost invariably cleans out the supraclavicular region, and that our rule ought to be "operate on the neck in every case." For this purpose, however, he does not divide the clavicle as he did five or six years ago, but if it were very desirable to remove the supraclavicular contents in one piece with the axillary contents and breast one need not hesitate to excise, if necessary, even the entire clavicle. He considers the neck involvement is no more serious than the axillary, and that the neck can be cleaned out just as thoroughly as the axillary region. He believes that in the near future we shall remove the mediastinal contents at some of our primary operations. It seems a pity he didn't throw in the liver and lungs when he was at it.

With every wish to defer to the opinions of those from whom I differ, I feel sure that they will permit me to state my views as plainly as many of them have stated theirs. Some little apology I may plead, viz.: that I have removed the breast and cleaned out the axilla over 250 times. It is a locality with which I am necessarily fairly familiar. Well, I have stated that I do not consider that carrying away the entire great pectoral muscle and dividing the small one are at all necessary for the satisfactory removal of the axillary contents. Moreover, I have given up attempting to get any good out of clearing out the supraclavicular region. In former days, when I thought I could remove any cancer, I did a good many cases, but never one survived. I do not say that I will not do it again if an apparently suitable case occurs. I did it twelve months ago on a lady who had a small cancer situated about an inch below the clavicle which had directly affected the cervical glands, but it was a failure, as usual. Dr. Coley in the article "Cancer" in "Twentieth Century Practice of Medicine," says:—"The only positive evidence Halsted's statistics afford us as to the value of this operation of cleaning out the supraclavicular fossa rests upon two cases in which the operation was done secondarily, and in which the patients remained well three and three-and-a-half years after the operation. In view of what I have already said regarding the failure of a three-year limit as establishing a cure of the disease, we cannot consider the question as settled with much stronger evidence." My motion is this, that when cancer has laid hold of the supraclavicular glands it has got such a grip as to be past extirpation. It is like a burning house. When the fire is beginning even some buckets of water will put it out; when it has got to a certain pitch a whole fire brigade will not quench it. Moreover, an experienced fireman will tell the minute he sees the fire whether he can put it out or not. Bennett May, in his Ingleby Lectures for 1897, says that he thinks it very doubtful whether some of these modern

extensive operative procedures confer any additional immunity from recurrence at all commensurate with their severity. It is clear that in both classes of operation the majority of fatal cases die of internal metastases without external recurrence—and against these no operation can protect. Dr. Hatas, of New Orleans, at a meeting of the American Surgical Association in 1899 said, speaking of Halsted and Meyer's operations, that he firmly believed that surgery had there nearly reached, if it had not already attained, its maximum expression of effectiveness, beyond which it is absolutely impossible to advance without great risk to life or with any further expectation of increasing the chances of permanent recovery. I entirely agree with Mr. Marmaduke Shield when he says that the swing of the pendulum of surgical opinion is generally too extreme and has now turned from too slight to too extensive operating.

One word more in reference to removing the great pectoral muscle. Do cancerous recurrences take place in the substance of that muscle? Are they found in the interval between the great and small pectoral muscles? Taking the latter query first, I have never seen such an occurrence. Referring to the first, I believe that when the great pectoral muscle is the site of recurrent growths they creep into it from the subcutaneous tissues and pectoral fascia. They do not primarily originate in the muscle. There is, therefore, no need for its removal on that ground. No man in this country has had more experience of the pathology of cancer than Mr. Plimmer, from his connection as pathologist to the Cancer Hospital. In a conversation with him the other day he perfectly concurred in this view, and, moreover, stated that he had never known anybody live long after distinct invasion of the supraclavicular glands.

I think I need say very little concerning the operation of Berger, which means removing the upper limb along with the scapula. It may be dismissed with the remark I once heard made by my friend Mr. Owen about another matter slightly altered from the French Marshal's observation about Balaclava—"C'est magnifique, mais ce n'est pas la chirurgie." Surely there are hypodermic syringes and morphia still in the land.

In the operation my plan has been this. I never make an angular, triangular or multi-angular incision for they are a farce. I draw a circular "ring fence" with a knife outside the apparent limits of the mamma if the tumour is central, and, if it is lateral, the "ring fence" should bulge well beyond the tumour. I then slip the blade on the flat beneath the skin for about two inches and undercut it all round. The skin is then well pulled back at successive points by an assistant, and where the undercutting stops there the removal begins. So one gets a long way beyond the rough limits of the mamma proper. Then the tumour is removed, and the fascia dissected off the great pectoral muscle. The great advantage of the undercutting is that one can get the fascia off the muscle as far inwards as the sternum, down to the ribs and up almost to the clavicle. As Mr. Butlin mentions, the removal of the fascia was one of the points dwelt upon by Dr. Gross and myself very many years ago. The axilla should then be opened by an incision just under the edge of the great pectoral and the upper end of the gland, and the whole contents of this cavity, as far as they can be held together, carried away in one mass. The importance of this lies in the fact that recurrence in the axilla takes place for the most part not in glands that are left behind, but in fragments of lymphatic vessels. I feel convinced of that. A good plan is to get hold of the axillary vein, and then there is nothing else to trouble about. One must take the matter very patiently, getting everything out of the cavity that can be got and cleaning up the digitations of the serratus magnus. On no account do I introduce the "sharpest possible knife" into the armpit nor any knife at all. I use a dissecting tool, two very long strong pairs of dissecting forceps and curved probe pointed scissors. But everybody according to his taste, except beginners who ought not to use knives here. A drain hole should now be made just above the edge of the latissimus dorsi, concerning the covering in of the great wound, it is remarkable what can be done towards pulling it together by very

strong wire and by the help of lead buttons. The very top of the axillary incision should be kept open. I put a little bit of gauze into this aperture and into the drain hole below. I wash my hands well with hot water and soap before operating. I pour hot water constantly over the wound during the operation and see that it is dry from blood at the end. I use no disinfectant fluids, and I dress the wound with a piece of perchloride gauze, and a pad of absorbent wool over it. I have used this plan of operating for over twenty years, and have only altered it slightly in the following points:—After reading my paper to the Harveian Society in 1887, so soon as I had recovered from my first discouragement, I proceeded to remove more skin than ever, for I became more and more convinced that skin is the really dangerous tissue in this matter of cancer of the breast. Thiersch grafting was not then invented, and so I had difficulty in covering the big wounds. It was then that I began the practice of undercutting, which I have demonstrated and taught ever since. If a wound of great size is left uncovered nowadays, we have the Thiersching to fall back upon. I have used it both at the time of operation and afterwards, when granulation was going on, and I prefer the latter plan.

A view is being now taught that there is great danger of infecting the wound with the knife that has made the exploratory incision through the tumour. I have seen no evidence whatever to this effect, and the extreme difficulty of getting the strongest cancer juice to reproduce anything in any cultivation medium is not in favour of it. Besides, let the operator wash his knife, if he is afraid of this accident.

Before leaving this subject I wish to make a few remarks, and I find great difficulty in making them, so much do I fear lest what I may say should be regarded in any way derogatory to the talents of two gentlemen for whom I have a very great admiration, Dr. Heidenhain and Mr. Stiles. In 1887, Mr. Butlin said with reference to mammary operations, "It was only during the writing of this book that I became impressed with the necessity for reconsideration on the subject." In 1898, in consequence of having read Dr. Halsted's paper, the results appeared to me to "justify a thorough reconsideration of the surgery of cancer of the breast." In this he was fortified by the work of Heidenhain and Stiles. Now the researches of these gentlemen on the minute lymphatics of the breast and neighbouring tissues, and the way cancer creeps into them are of the greatest interest from an anatomical point of view. But I do not see that they have done anything very specially to influence the views of men who are occupied practically in endeavouring to eradicate mammary cancer. Dr. Coley says:—"Still later, in 1889, Heidenhain, by his careful and scientific investigations as to the manner in which cancer cells extended from the original focus of the disease into the neighbouring parts demonstrated the facts, many of which Moore and Gross had already from clinical observations previously assumed as true. The gist of Heidenhain's results may be summed up in a few words. A cancerous tumour that has become sufficiently large to be recognised clinically has already scattered its infective cells throughout the entire breast, the neighbouring chain of glands, and in many instances the fascia overlying the pectoral muscle." Quite so, but there was no surgeon in 1889 who did not know this as a matter of fact, although the question had not been demonstrated by the microscope. It was not that surgeons did not know this; it was that they were not bold enough to act on their knowledge. In justice to myself and to the memory of my late friend, Gross, I think it rather hard that a certain group of surgeons should date the origin of the modern operative treatment of cancer from the microscopic investigations of Heidenhain and Stiles and the labours of Halsted and themselves.

I am sorry that during the removal from our old Liverpool Infirmary to the present one the histories of many cases were lost. But though mistakes there may be, I am certain that they cannot be sufficiently numerous to invalidate in any way any general conclusions that may be drawn from them. The cases number 213, of which 175 are available for statistical comparison. In Series I it is noteworthy that of the sixty-seven persons who

died of local recurrence seventeen lived for periods between three and thirteen years. Series II shows thirty-eight persons alive and well between three and twenty-one years after the operation. To Series III it may be objected that I cannot prove that some of the patients did not die from internal recurrence. It is a fair argument, and all I can reply is that I have taken all the pains I could to make sure of the causes of death, and have put any doubtful ones into Series IV. But, after all, if a breast cancer seems a fit subject for removal, we do not speculate on internal recurrence, for our business as surgeons is to find out whether we can eradicate the disease locally, so that we may be able to give patients who apply early for relief a good prospect of future immunity. Now the first four series comprise 175 patients, and of these 108 have remained free from local recurrence. Of the 108, 73 lived over three years as follows:—

Cases that lived between 3 and 6 yrs. after operation,	40
" " " 7 " 14 " " "	28
" " " 16 " 21 " " "	5

Take out of these 73 half-a-dozen in case of errors, and it still follows that for every one of my 67 failures I can pit against it a case where the patient remained free from 3 to 21 years. With regard to tables of statistics in general, the plan of taking percentages of small numbers of cases ought to be abolished. The figures in a surgical article nowadays make it look like an extract from an accountant's report on a bankrupt case. As for the three years cure system, it too must be abolished, if people are to be instructed fairly. Let no woman be reckoned cured of cancer of the breast till she is dead. And now, gentlemen, I have only to thank you.

Clinical Records.

A CASE SIMULATING A PERFORATING GASTRIC ULCER. (a)

By DR. J. W. THOMPSON AND MR. CONWAY DYER, F.R.C.S.I.

A FEMALE, *æt.* 23, with a distinctly tuberculous family history, had never been seriously ill until five or six weeks previously, when she commenced to suffer from stomach trouble. In the beginning of the attack she had discomfort and flatulency after food, with a tendency to nausea and a failing appetite. Later on she complained of pain, at first localised to pit of stomach, and afterwards extending to back, which commenced shortly after food, and lasted a couple of hours, and was frequently followed by vomiting. She never suffered from constipation. About one hour after having bread and milk for supper, which was followed by the usual pain and discomfort, the pain in epigastrium became suddenly severe and agonising, and was followed by vomiting. The vomited matter was said to be dark, and reddish in colour, otherwise there was no evidence of hæmorrhage. The pain got worse during the night, and became more diffuse. The patient looked thin and anæmic, and seemed to be suffering great pain. The epigastrium and upper portion of the abdomen extending towards the left was distended, rigid, and tender on percussion. The liver dulness was not affected. She was admitted to Jervis Street Hospital, and it was decided to operate. Just before operation, and about 14 hours after the supposed perforation, all the abdominal symptoms had become more aggravated, the temperature was 102, pulse feeble and 140 per minute, and respiration shallow and thoracic, and 34 per minute.

Mr. Conway Dwyer performed the operation. The abdomen was opened by an incision extending from the ensiform cartilage to a point slightly to the left of the umbilicus. Owing to the great rigidity of the left rectus muscle, which persisted even under deep ether narcosis, it was found necessary to enlarge the incision transversely before sufficiently free access could be obtained

(a) Read at Meeting of Royal Academy of Medicine of Ireland, March 7th, 1900.

for exploration. The anterior wall of the stomach was then examined, and presented nothing abnormal. Before examining the posterior wall it was deemed advisable to explore the abdominal cavity lower down. The incision was accordingly enlarged in a downward direction, and a coil of jejunum was brought into view in an intensely congested condition, and having on its surface two gangrenous patches situated closely together, and involving a third of the calibre of the bowel. No perforation had as yet taken place, but such a result was inevitable had the operation been delayed. The coil was drawn out, isolated by gauze (iodoform) strips, the contents of the loop gently pressed downward, clamp applied, and resected; the junction of the divided intestine effected with a Murphy's button, the abdominal cavity was flushed with sterile saline solution. The wound was closed, all but the lower angle, through which was carried a gauze drain, and placed close to the sutured bowel. The subsequent history was uneventful. The bowels moved five days after the operation, and the button came away on the eighteenth. This case is of interest as exhibiting the liability to error in interpreting the precise conditions that produce severe abdominal symptoms. The previous history, the sudden nature of the attack, the localisation of the pain, all pointed to a perforating gastric ulcer—in fact, the physical signs and symptoms of this condition were present in their due sequence and severity, with the single exception of unaltered area of liver dullness; the absence of this last has, however, frequently been noticed. The lesion present was, I am of opinion, due to infarction. I hazard this explanation, as unfortunately the portion of intestine removed was mislaid. The lesson to be learned from such cases is to operate at once. If surgical aid is unavailing or unnecessary no harm can be done, while life may be saved by prompt interference.

CASE OF REMOVAL OF APPENDIX CÆCI.

By Dr. P. G. LODGE,
of Bradford.

Miss A. B., æt. 18, Lidget Green, has a history of pain in the right iliac fossa of some months' duration. At intervals this pain has been of a severer type, causing colic and occasionally vomiting; otherwise healthy and well nourished. Operation for the removal of the appendix was fixed for May 13th, 1899. On that day the patient, previously prepared, was anaesthetised by Dr. B. Wade. Chloroform was given in a Junker's inhaler. An incision, three inches, was made at right angles across a line drawn from the anterior superior iliac spine to the umbilicus, at the junction of its inner and middle thirds. The layers of the wall of the body were consecutively divided on a director until the peritoneum was reached and carefully opened; any hæmorrhage was controlled with catch forceps and treated in the usual way. The abdomen was very deep, and it required much manipulation with the fingers introduced before the cæcum and appendix appeared at the retracted opening. The appearance of the appendix was not greatly altered from the normal, its free end was slightly bulbous, and it felt very firm and cord-like; a few dilated vessels were made out upon it. There were no signs of inflammation about the peritoneum of adjacent viscera, but too much time was not lost in these investigations. I decided to remove the appendix. As a first step I resected a flap of peritoneum at the attached end of the appendix. I next tied a ligature round the uncovered stump, and carefully removed the appendix with a pair of scissors. Three small sutures of fine catgut secured the peritoneal flap over this. The site of these procedures bulged in a direction away from the cæcum, the opening into the appendix having been funnel-shaped. The site was made more secure by one or two more sutures, bringing the peritoneum into contact so as to form a fold over the site of former operations. There was very little staining with blood about the peritoneum at all; the mounted sponge introduced for cleansing purposes was scarcely stained, in fact, very little disturbance of the arrangement of parts within the body was caused. The peritoneum was now closed with a

running stitch of catgut; the muscular fibres were secured by interrupted stitches of the same substance, and the skin closed by sutures interrupted, of silk worm-gut. Dressings were applied, and the patient returned to bed. At no time during recovery was the temperature higher than 99 degrees. After the third day the temperature was quite normal always. The bowels moved on that day. There were no other complications, the superficial stitches were removed on the eighth day, and primary union was effected.

The girl is now able to get about, and she waits on in a shop. Occasionally she has a little twinge of pain about the body. For obvious reasons no further detailed examination of the ovaries or other organs has been attempted. On examination of the removed appendix very little coarse lesion was observed; there was no foreign body or pus in its lumen; a folded arrangement of its lining epithelium was easily made out, and it felt very hard as a whole. I am of opinion that in spite of repeated attacks and exact localisation of pain over McBurnie's point, this case was one of those which would perhaps have recovered under medical care alone, but the peritoneum is still tender and bruised many months after operation. I found discoloration post-mortem of peritoneum wide in extent in a case at the Bradford mortuary, as many as 12 weeks after recovery from a radical cure for inguinal hernia, this man having died from other disease and excesses. Therefore the twinges mentioned as still occasionally occurring may be reasonably expected to disappear. The girl is and has been throughout, in splendid condition of health otherwise.

Transactions of Societies.

OBSTETRICAL SOCIETY OF LONDON.

MEETING HELD WEDNESDAY, APRIL 4TH, 1900.

Mr. ALBAN DORAN, F.R.C.S., President, in the Chair.

SPECIMENS.

Impacted Myoma in a Young Subject.—Dr. C. J. CULLINGWORTH showed a myoma removed on account of impaction from a young woman, æt. 23. She had had a good deal of hæmorrhage, but only once had there been any trouble with the bladder. There was no doubt that she would soon have suffered considerably from the bladder if not relieved. The uterus was in a condition of retroflexion, and the cervix was so elongated as to admit the sound for the length of 2½ ins. This gave the impression that the uterus was of normal length, and more or less independent of the tumour. Cases of uterine myoma in women under 25 were so infrequent that he thought that every case ought to be put on record.

Myxomyoma with Sarcomatous Degeneration.—Dr. ARTHUR STABB showed a specimen of subserous pedunculated fibroma with myxomatous degeneration; the histological examination suggested that part of the growth was sarcomatous.

Dr. WILLIAM DUNCAN suggested that in view of the importance of the specimen, it should be referred to a pathological committee.

Dr. HERBERT STENGER also emphasised the importance of these cases; several supposed fibroids had been proved, by the subsequent history, to be sarcomatous. He referred to a case in which he had operated for what he thought was a fibroid tumour. He learned four years later that she had died of sarcoma three years after the operation. He had also had two other somewhat similar cases.

Tubal Mole.—The PRESIDENT showed a perfect specimen of a tubal mole, in which the fœtus was well-preserved. The hæmorrhage under the amnion had been limited in extent.

Dr. WILLIAM DUNCAN showed a specimen of what he regarded as a tubo-ovarian gestation. The ovary could be recognised as forming part of the wall of the sac.

Fibroma of the Ovary.—Dr. A. W. ADDINSELL showed a specimen of this rare form of tumour. He referred

to the different views held on the subject, viz., (a) the view that all these tumours were in reality sarcomata; (b) the view that they were all myomata; (c) the view, which was the one he also held, that true fibromata of the ovary occurred.

The PRESIDENT remarked that in his experience, so far from supposed fibromata of the ovary turning out to be in reality sarcomata, a considerable number of supposed sarcomata had proved to be fibromata.

Large Suppurating Ovarian Cyst Complicating the Puerperium.—Dr. MACNAUGHTON-JONES read the notes of a case in which the patient, after nine years of married life, was delivered of a healthy child. The pregnancy had been normal. A few days after delivery the temperature and pulse rose, and on the fourth day the patient had a rigor. A hectic temperature was present for some time. When he saw the patient, in the Stanmore Cottage Hospital, he diagnosed a suppurating ovarian cyst; and operation was performed on the forty-third day after delivery. The operation was long and difficult, on account of the great number of adhesions. About half a painful of pus was evacuated. A drainage tube was inserted. On the third day after the operation the temperature fell, and the patient made a good recovery.

Dr. HERBERT SPENCER thought this was not a very unusual case; he had always understood that the incidence of labour was one of the commonest causes of suppurating of ovarian tumours; he had met with five or six cases of this kind. The cause of the suppurating was not very obvious, it was perhaps due to lacerations occurring during delivery.

Dr. W. S. A. GRIFFITH attributed the infection in these cases to the damage done to the tumour by pressure during delivery.

Sarcoma of the Vagina in a Child.—Dr. ARNOLD LEA (Manchester) showed a sarcoma removed from the vagina of a child, æt. 2½. When he first saw the child the growth protruded through the vulva. Owing to involvement of the recto-vaginal septum and the interior vaginal wall, it was impossible to do a radical operation, and he had to content himself with curetting away as much of the growth as possible. The child lingered for nearly 18 months, and died of exhaustion. Microscopically, each polypoid projection of the growth was covered by the stratified vaginal epithelium.

Dr. LEWERS had had several such cases; but they had all turned out to have arisen from the uterus primarily.

THREE CASES OF INCARCERATION OF THE RETRO-DISPLACED GRAVID UTERUS AND ONE OF EXTRA-UTERINE PREGNANCY SIMULATING THAT CONDITION.

This paper was read by Dr. J. M. MUNRO KERR, Glasgow.

The author pointed out that three varieties of backward displacement of the gravid uterus were met with, viz., "retroflexion," "retroversion," and "partial or incomplete retroversion," and that each form was illustrated by one of the cases. Case 1.—An incarcerated, retroflexed, gravid uterus, which after several fruitless attempts at replacement righted itself. This occurrence was pointed out to be not very uncommon. Case 2.—This case was reported in full by Professor Murdoch Cameron, in the *British Medical Journal*, October 31st, 1896. It was one of incarceration of the retroverted gravid uterus, in which the uterus could not be replaced until Professor Cameron opened the abdomen, then performed cystotomy and emptied the bladder of a large quantity of blood-clot. He then stitched up the bladder and abdomen. The pregnancy continued to full time. The treatment adopted in this case was discussed. Case 3.—Partial retroversion (sacculation) of the gravid uterus caused by a myoma in anterior wall. Reduction of the displacement; continuance of pregnancy. The causes of this form of retro-displacement were described. Case 4.—Extra-uterine pregnancy simulating and mistaken for a retroflexed gravid uterus. Some reported cases were referred to, and the differential diagnosis of the two conditions was discussed.

The PRESIDENT, after thanking Dr. Munro Kerr for his interesting and practical paper, said that he had not himself met with a case in which an extra-uterine gestation was mistaken for a retroverted gravid uterus; but

fifteen years ago he saw an instance in which a retroversion of the pregnant uterus was mistaken for an extra-uterine gestation. The patient in the third month of pregnancy had violent attacks of pain; the uterus was felt, apparently, to the right, and a tumour to the left. She was sent into a home, and on examination he thought the cervix was higher up than before, so he decided to wait before operating. In a few days the uterus righted itself. He also referred to a remarkable case of complication of retroversion of the gravid uterus recently recorded by Unterberger at Königsberg. Pressure on the bladder had led to the opening up of the canal of the urachus, and to discharge of urine through the umbilicus.

Dr. ARTHUR GILES said that as Dr. Munro Kerr had referred to the two cases he had recorded, in which an extra-uterine gestation was mistaken for retroversion of the gravid uterus, he need not dwell on these; but he called attention to a case in which, as in the President's case, a retroverted uterus simulated ectopic gestation. He had seen the case with Dr. Martin, of Clapham Junction. Under an anæsthetic the mass in Douglas' pouch was reduced, and then appeared to be distinctly bilobed. The mass on the left felt like a gravid tube. She had had sharp pain on the left side. He advised watching the case for a fortnight, and at the end of that time the uterus had resumed its normal shape.

Dr. LEWERS criticised the treatment in the second case reported by Dr. Kerr. In the course of fifteen years at the London Hospital, he had seen forty to fifty cases of retroversion of the gravid uterus; had never met with one in which an abdominal section was necessary in order to rectify the condition. He did not think that they should by silence allow of the inference that the Society considered that laparotomy was a recognised procedure in the treatment of this complication. It seemed to him that in Dr. Cameron's case it would have been possible to evacuate the hemorrhagic bladder-contents through the urethra, and then by rest and the use of chloroform, if necessary, no doubt the uterus would have righted itself, or could have been replaced.

Dr. R. BOXALL was glad Dr. Lewers had called attention to the value of rest and chloroform in these cases. He also had had a case in which the symptoms and signs resembled those of extra-uterine pregnancy; the patient was sent into hospital and put under an anæsthetic, when it was found that the uterus had resumed its normal position. A myoma was also discovered in the posterior uterine wall.

Mr. C. A. MORRIS mentioned a case at St. Bartholomew's Hospital in which the gravid uterus was retroverted, and the pressure on the bladder was so great as to lead to effusion of blood into this viscus. The bladder was emptied, and the uterus righted itself without requiring abdominal section.

Dr. HUBERT ROBERTS said that he did not know of any case having occurred at St. Bartholomew's Hospital in which abdominal section was required for retroversion of the gravid uterus.

Dr. AMAND ROUTH spoke similarly with regard to Charing Cross Hospital. In one case the bladder was so distended that it contained 150 ozs. of urine, and for some time afterwards it was not able to empty itself completely. Some years ago he had seen a case of retroverted gravid uterus simulating hæmatocele.

Mr. BUTLER-SMYTHE thought that the opening of the abdomen and of the bladder was a very severe treatment for Dr. Kerr's second case. He agreed with Dr. Lewers that it might have been dealt with by evacuation of the blood through the urethra.

Dr. HERBERT SPENCER expressed a similar opinion. All the cases he had seen of retroverted gravid uterus had been able to be replaced sooner or later. Even when some adhesions were present these would probably yield after a time.

Dr. MUNRO KERR, in reply, said that Dr. Lewers had stated that he had seen perhaps 50 cases of retroversion of the gravid uterus, in which abdominal section was not necessary. This was not a very large number. Martin, of Berlin, had seen 149 in which this treatment was not necessary. The fact that various speakers had had no occasion to open the abdomen in such cases did

not alter the fact that there were cases in which abdominal section was the only possible course. Such cases had been reported by Jacobs and by Sanger. In Hunter's historical case it was not possible to replace the uterus even in the post-mortem rooms until the symphysis had been divided.

ROYAL ACADEMY OF MEDICINE IN IRELAND. SECTION OF MEDICINE.

MEETING HELD FRIDAY, MARCH 9TH, 1900.

The President, Dr. JOHN W. MOORE, in the Chair.

EXHIBITS.

Dr. CONOLLY NORMAN showed three cases illustrating the relations of insanity to tabes dorsalis.

Dr. NORMAN, in reply to a question put by Dr. Walter Smith as to the association of insanity with tabes in these three cases, said that the association in the first case was probably only accidental. It might be that Cases 2 and 3 would some day develop symptoms resembling those of general paralysis, which would bring them into line with those cases seen every day, in which tabes appeared first and then general paralysis. Of course, tabes dorsalis, like every other nervous disease, probably attacked, pre-eminently, those inclined to nervous failure. Referring to general paralysis associated with tabetic trouble, he pointed out that lesions had been traced in general paralysis in every part of the nervous system from the cortex to the nerves. From time to time they were wont to see the occurrence of cerebral crises, which were remarkably like the other visceral crises, which tended to show that the cerebral trouble was similar to elsewhere. He got from one to three cases per annum of locomotor ataxia which had gone round the Dublin hospitals, and then terminated with him, and turned out to be general paralytic cases. Replying to Dr. Dawson, he said the remissions of symptoms gave the first case a peculiar character, and it was to be noticed that there were remissions in the tabetic symptoms as well, although they were not so well marked. The patient was at one time so tabetic that he could not walk at all, but he was now able to get about.

A FATAL CASE OF CONGENITAL BULLOUS ERUPTION.

Dr. R. H. KENNAN discussed the two great classes of cases in which bullæ appear on the infant—the so-called pemphigus neonatorum and the pemphigoid eruption of hereditary syphilis. The principal points of interest in his case were the fatal termination, the remarkable localisation of the bullæ, the complete absence of history or sign of syphilis in either parent or surviving child, and of evidence of this taint post-mortem, though the organs, epiphyses, and skin were carefully examined microscopically.

Dr. LANGFORD SYMES said this case resembled one he saw some years ago, but the bullæ were not so prominent, and it was more a case of violent purpura than this case. It was in a two or three weeks' old child, which died within four or five hours of its admission to hospital. It had been described by German writers as purpura fulminans, and the blood-stained fluid described by Dr. Kennan seemed to point in this direction.

Dr. WALTER SMITH said that bullæ were produced on the skin under such diverse conditions that it was doubtful how far they were to accept a particular generic word such as pemphigus. He objected also to placing a skin affection due to a distinct ætiological factor, say syphilis, under the same name as one not due to a distinct cause. They often saw pemphigus in connection with acute dermatitis, such as erysipelas, and even in ordinary scabies he had seen very large bullæ occur, as well as in cases of neuritis, such as herpes zoster and traumatic affections of nerves. In the class due to unknown causes he would rank cases to which he would like to apply the term pemphigus. He defined pemphigus as "an eruption of abruptly defined, fragile, thin-walled bullæ, upon a non-inflamed surface, symmetrical, and prone to relapse."

Dr. J. W. THOMPSON and Mr. CONWAY DWYER contributed "Notes on a Case Simulating Perforating Gastric Ulcer," which will be found under "Clinical Records."

Dr. R. TRAVERS SMITH asked if any cause had been found why the coil of the jejunum should have become gangrenous.

Dr. CRAIG said that so long as liver dulness was present he would hesitate in giving a diagnosis of perforation into the abdominal cavity, though rupture might take place into an abscess on the posterior wall of the stomach without the occurrence of this sign.

Dr. DOYLE said that it had not been proved that there was no gastric ulcer in this case, though there was certainly no perforation.

Dr. KIEKPATRICK related a recent case diagnosed as perforated gastric ulcer ten hours before being sent to hospital. Although the liver dulness was apparently normal before operation, which was done two hours after admission, a small perforated ulcer was found on the anterior wall, and the contents of the stomach were found in the abdominal cavity.

Dr. LITLEDALE asked if the condition was due to an infarction of the intestine. If there was no adhesion found that might be a possible explanation of the condition. He considered that the mesenteric vessels were not sufficiently examined in such cases.

Dr. PEACOCK recalled a case under Mr. Gordon's care with acute symptoms like strangulation. They could feel the coil of intestine through the abdominal wall. After laparotomy an almost gangrenous coil of intestine was found, but no bands nor adhesions, and the conclusion came to was that a thrombus had formed owing to syphilitic affection of the arteries.

Dr. PARSONS said that there was no point to which he attached more importance in diagnosis than the abolition of the area of hepatic dulness. One other point of importance was a steady increase in the rapidity of the pulse. The temperature was of no value, as in the worst cases they found subnormal temperature, and in most cases he had seen there was no febrile reaction.

The PRESIDENT (Dr. J. W. Moore) said he remembered a case in the Meath Hospital in which a perforated gastric ulcer produced all the symptoms of empyema, and tapping confirmed this diagnosis. There was also a discharge of pus from the bronchial tubes. The autopsy showed that the abscess was below the diaphragm, which it had perforated.

Dr. THOMPSON, in reply, said that in the most recent work on the subject the absence of liver dulness was stated not to be an absolute sign, neither was the absence of hæmatemesis.

Mr. DWYER said that an examination had not been made, as the specimen had been mislaid, but he had no doubt that it was due to a thrombus owing to the sharply defined nature of the gangrenous patches and the absence of adhesions. Mr. Treves had described many cases of that kind.

The Section then adjourned.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD THURSDAY, MARCH 22nd, 1900.

MR. EDGAR BROWNE, F.R.C.S.E., President, in the Chair.

CASES.

Dr. K. GROSSMANN showed a case of "Double Congenital Anophthalmos" in a child eleven weeks old. The eyelids turned inwards and opened through a small rima into a conical space lined with conjunctiva; the eyelashes well formed, with an absence of puncta lachrymalia. The conjunctiva at the fornix forms a straight cone, whose apex in the left eye is a whitish, and in the right eye a blueish point. The well-developed state of the adjacent structures indicates that the arrest of development of the eyeballs, and their probable subsequent disappearance has taken place at an advanced stage of fetal life.

Dr. W. B. BENNETT showed a woman suffering from motor aphasia, right hemianæsthesia, and paralysis of the right side of the tongue, but no hemiplegia. He

considered the lesion to be a softening in the sub-cortical area of the brain.

Mr. G. REINHARDT ANDERSON read notes of a case of "Strangulated Obturator Hernia" in a woman, *æt.* 75. Patient was seized with pain in the left thigh and vomiting. When first seen, twenty-four hours later, the vomiting had ceased, and the pain was not so marked; next day all the symptoms pointed to complete obstruction; fecal vomiting and abdominal distension. There was some fulness in the left femoral region, and the diagnosis was that of partial enterocele in the left femoral canal. Operation by incision over the femoral region revealed nothing, the lump felt being an enlarged gland; the patient was unrelieved, and too ill apparently for laparotomy. Five hours later the femoral wound was reopened, and a deep dissection revealed a hernia through the obturator foramen; this was reduced, and the patient made a rapid recovery, and is now well.

Mr. RUSHTON PARKER congratulated Mr. Anderson on the promptitude with which he had acted and thus saved the patient's life. The condition was one of great rarity, and in an operative experience of 510 herniotomies, he had never met with obturator hernia.

Dr. LLOYD ROBERTS described the sequence of the symptoms and physical signs in the course of a typical case of mediastino-pericarditis, and read notes of a case he had met with in a boy, *æt.* 5.

Dr. WM. ALEXANDER read a paper on the

PREVALENCE OF OPHTHALMIA IN LIVERPOOL:

its prevention and treatment. In three years nearly 1,000 cases of ophthalmia in various forms had been admitted into the Liverpool Workhouse Infirmary. They all came from the lowest parts of the city, and many of the children were admitted direct from their attendance at school. In one-tenth of the cases there was impairment of vision, some were temporarily blind, and in many the eyes were hopelessly lost. To prevent the disease it would be necessary to have ophthalmia notified as a contagious disease and arrangements made for the effectual treatment of each case notified before its return to school. The patients' homes should be visited and all the family inspected, for often other children had acquired the disease in a latent form. All schools should be periodically visited and latent cases eliminated. The treatment of granular lids was described as hygienic and local, and the methods for the former, adopted by the select vestry discussed. He thought the best results in the treatment of trachoma were obtained from the use of the solid sulphate of copper in cases where the discharge was slight and the granules distinct; when the discharge was greater he used nitrate of silver solution. The relations between follicular conjunctivitis and granular lids were discussed, and it was shown how difficult it was to diagnose one from the other. Follicular conjunctivitis is comparatively rare in Liverpool, and many surgeons are doubtful of its existence as a distinct disease.

The paper was illustrated by cases, photographs, drawings and lantern slides.

Dr. K. GROSSMANN urged the importance of classification, and considered the follicular and granular forms as distinct diseases, and not as stages in the same disease. Granular conjunctivitis he considered a rare disease in Liverpool after a long hospital experience in one of the poorest parts of the city. The clinical facts are the guides as to prophylaxis and treatment.

Dr. A. S. GRIFFITH stated that in every case of mucopurulent catarrh he had found the Koch-Weeks bacillus; in the scanty discharge of chronic granular conjunctivitis there was no organism found to which the condition could be ascribed, but when trachoma developed the Koch-Weeks bacillus was found in large numbers. He assumes that bacilli enter the tissues, and, acting as an irritant, result in the formation of granules, and that the particular bacillus is probably Koch-Weeks bacillus acting with a small amount of virulence.

Mr. Richard Williams, Mr. Bickerton, Dr. Hoare, Dr. MacAlister, Professor Boyce, and Mr. C. G. Lee also took part in the discussion, and Dr. Alexander replied.

BRADFORD MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD MARCH 10TH, 1900.

the President, Mr. HORROCKS, in the Chair.

CASES AND SPECIMENS.

Dr. BRONNER showed four cases of mastoid disease demonstrating the different methods of operation.

Dr. KERR showed a case of chronic adenitis of the lachrymal, parotid, and submaxillary glands. The patient was a girl, *æt.* 11, and she complained of the "eyes hurting her," especially at the outer part. Vision normal. The trouble had commenced with enlargement of both lachrymal glands, which were notably prominent and indurated, but not acutely inflamed. This was followed by swellings of both parotid and submaxillary glands, the enlargements being nodular and of almost cartilaginous hardness. There was a slight tenderness on deep pressure over the enlarged glands. There was some dulness on percussion over the sternum suggesting enlargement of the thymus. The temperature was 100°-101° for three weeks, and there was very slow remission of symptoms. The case has now been going on for two months, the temperature is normal, but the pulse is 120. Dr. Kerr suggested that the case might be one of chronic mumps.

Dr. CAMPBELL showed a marked case of Hodgkins' disease. The disease was steadily getting worse. Administrations of arsenic had been followed on each occasion by a sudden rise in temperature, the temperature falling when the arsenic was discontinued.

Dr. LANKESTER showed the heart from a case of ulcerative endocarditis affecting the aortic valve only. The patient, a lad of 18, had been in good health till the receipt of a blow on the chest, after which he developed symptoms of heart disease, and on seeking relief at the infirmary was found to have a basic systolic murmur, but no diastolic murmur. He recovered to a large extent and left the hospital. In a few weeks was readmitted with very urgent symptoms of heart failure, together with a high temperature, and he died shortly after admission. Post-mortem.—The heart showed hypertrophy and dilatation of the left ventricle together with ulceration and agglutination of the cusps of the aortic valve. The mitral valve was healthy.

Dr. JASON WOOD showed a specimen of cancerous peritonitis, secondary to disease of the ovary.

APPENDICITIS.

Dr. J. METCALFE read notes of a case of appendicitis. The attack commenced with vomiting, constipation and fever. A swelling was felt in the right iliac region, which was dull to percussion, but never became fluctuant. The fever showed intermissions several times. During the fourth week of illness, and when the temperature had been normal for some days the patient had a sudden attack of pleurisy on the right side; signs of fluid were present, but none was obtained by explanatory aspiration. Patient was quite well at the end of seven weeks. Dr. Metcalfe considered the pleurisy as due to direct infection along the lymph channels. The treatment of cases of appendicitis was discussed. The reader of the paper considered that surgical interference was only advisable in cases of recurrent appendicitis, or in cases where there was direct evidence of pus being present. Dr. Metcalfe stated that appendicitis is more common in boys than in girls, and attributed this to their habit of "bolting" their food, of eating very indigestible things, and their greater liability to direct injury from blows, &c. Ribbert's investigations as to the length and calibre of the appendix at different ages were alluded to, and the suggestion was made that irritating matters were more likely to be retained in the relatively longer appendices of young people.

A discussion on the treatment of appendicitis followed, in which several members took part.

Mr. ALTHORP showed a patient, and read notes of a case of arterio-venous aneurysm of the cavernous sinus. The trouble had supervened on an injury causing a fracture of the base of the skull. Marked proptosis came on with rapidly increasing defect of vision in the only

remaining eye. Ligature of the common carotid artery was performed with a very satisfactory result.

Dr. ANGUS showed a specimen of embolism of the left common iliac, left external iliac, left femoral and right external iliac arteries from a patient who had suffered from double mitral disease. He had a sudden attack of paraplegia, affecting the left leg more than the right. Pulsation was at first absent in both femoral arteries, but returned in the right on the day following the attack. The paralysis gradually improved, and the patient died ten weeks later from heart failure. Post-mortem—the heart weighed 26 ozs. The left auricle was dilated, and the mitral orifice contracted. A firm clot extended from the bifurcation of the aorta to beyond the origin of the deep femoral on the left side, and another occluded the right internal iliac. Efficient collateral circulation appeared to have been established, as there was only a small superficial patch of necrosis on the left heel.

Dr. ENRICH related the notes and showed microscopical sections from a case of disseminated sclerosis. The case only extended over about three months, and was under observation during the whole course.

SHEFFIELD MEDICO-CHIRURGICAL SOCIETY MEETING HELD MARCH 29TH, 1900.

The President, Dr. BURGESS, in the Chair.

Dr. SINCLAIR WHITE showed (a) a sarcomatous scapula removed from a man, *æt.* 42. The tumour occupied the supraspinous fossa and had a history of four months' duration. There was no special difficulty encountered during the operation and the patient made an uneventful recovery. (b) A sarcomatous left upper jaw removed from a girl, *æt.* 8. Although practically the whole of the superior maxilla was excised there was very little deformity. (c) A cancerous rectum excised after the method of Kraske from a male, *æt.* 42. The fæces were diverted by a preliminary colotomy, and the artificial anus subsequently closed by a plastic operation. The patient was rapidly regaining health and strength.

Dr. BURGESS showed (1) a malignant growth of spinal column; (2) a case of cerebral diplegia in a child, and read notes of another case of that disease in an adult, *æt.* 29; (3) a case of locomotor ataxy with aortic aneurism.

Dr. PORTER showed (1) a melanotic sarcoma of spinal column; (2) a case of aortic aneurism.

Mr. H. HALLAM showed (1) a case of sporadic cretinism in a woman *æt.* 48; (2) a girl, *æt.* 14, niece of the above, with an enlarged thyroid. Her parents were cousins, her father being brother of the first case shown. No definite symptoms of cretinism were present, but there was a suggestion of coarseness of hair and features. (3) A case of cretinism in a boy, *æt.* 11, who had markedly improved after three months' treatment with thyroid extracts.

Dr. GODFREY CARTER read a paper on

ELECTRIC HEAT AND LIGHT BATHS,

and illustrated more especially the systems of Greville and Dowsing. He pointed out that the hot bath flourished in England during the first three centuries of the Christian era, and then it fell into disuse, but was transmitted through the intervening centuries by the Turks. It is about fifty years ago that the Turkish bath was introduced into England. Its method was by the use of hot-air blasts and radiation from heating plates. But its great disadvantage was that the patient breathed the hot air of from 125 to 240° Fahr. Few people, however, can inhale hot air at a temperature of from 150 to 200° Fahr. without incurring great risk. The human body is capable of supporting, with impunity, exposure to an atmosphere far above that of boiling water, provided that the air be dry, and not inhaled. In the Greville system heat only is utilised, while in the Dowsing both light and heat are brought to bear. Exposure of the part to be treated usually extends from twenty to forty-five minutes, beginning at a temperature of 240° Fahr., which is gradually raised to 350° and

400° Fahr. The cases most benefited are those of sciatica and lumbago, as well as chronic gout and rheumatism, painful and stiffened joints, and such lesions as football sprains. An exhibition of the Dowsing apparatus in operation concluded the subject.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, April 8th, 1900.

PERITONITIS

At the last meeting of the Académie de Chirurgie, M. Moty said that he was called to a patient suffering from diffused peritonitis produced by inflammation of the appendix. After ablation of that organ by the thermocautery and absterion of a certain quantity of pus diffused among the loops of the intestine and in the neighbourhood of the appendix, he treated the congested portions of the intestine with boiling water rapidly applied. Under the influence of these compresses, the intestine recovered in about twenty seconds its normal colour, and the patient made a quick recovery. M. Reclus said that he had frequently observed the good effects of hot water on infected portions of the intestine, especially in the treatment of penetrating wounds of the abdomen. M. Desprès was in the habit in his operations for strangulated hernia of washing with boiling water the strangulated loop of intestine, and the results were very favourable.

M. Lucas remarked that twenty-five years ago, Lister had insisted on the advantage of employing antiseptic solutions at a high temperature.

SORE THROAT AND SALICYLATE OF SODA.

M. Meyer, at the Académie de Médecine, drew attention to the surprisingly good results obtained in pseudodiphtheritic tonsillitis, and in the common form of sore throat from gargles of solution of salicylate of soda, one drachm to 6 ozs. of vehicule, generally water. He treated in this way 300 cases of tonsillitis, pharyngitis, laryngitis, and considered salicylate of soda used as a gargle as almost a specific for all inflammatory affections of the throat. That opinion was corroborated by Dr. Mignon, the chief of the Medical Service of one of the preparatory schools of infantry. According to him it was not necessary to prescribe large doses of the salicylate of soda; from one to two drachms was a daily dose, which he never exceeded. The patient put a tablespoonful of the solution into half a glass of hot water and gargled his throat every hour. The painful sensation disappeared with astonishing rapidity, and he rarely witnessed the inflammation resist more than two or three days when the affection was treated at the outset. Having the medical care of over 400 young men, he had treated times without number sore throats by the above simple method, and always with success. Patients subject to repetitions of tonsillitis had only to use the gargle at the first symptoms of the malady to arrest it within forty-eight hours.

MEDICAL STUDENTS IN THE FRENCH FACULTIES.

The number of medical students in the different medical faculties for the present year shows a slight decrease (39) to last year. The total matriculated is 8,230, of which 817 are foreigners. But if this figure is compared with those of the past decade it would appear that the total number of students had diminished by 688, and

this decrease affected the French students as well as the foreigners. As regards the latter, 206 are inscribed for the University diploma which does not carry with it the right to practise in the country.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, April 7th, 1900.

At the Medical Society (March 21st), Hr. Hans Hirschfeld reported further on a subject mentioned at the last meeting of the Society by Hr. Ewald, viz.: on

PAINTING WITH FORMALINE IN THE SWEATING OF PHTHISIS.

By the aid of certain precautions, covering the patient with "paradouble" impervious to formaline, protecting the nostrils with plugs of lint soaked in turpentine, formaline did no harm to the respiratory organs. Patients experienced no inconvenience, and in 100 cases in which it was employed, no failure took place, although one half of the cases were such as had derived no benefit from antihydrotics. In some cases a single painting was sufficient to prevent a return of the sweating for some weeks, others required two applications, and in three the painting had to be done three times before a salutary and lasting success effect followed. No visible effect was produced on the skin except a slight scaliness and in one case a mild urticaria and two slight erosions. But formaline was anything but an indifferent substance, and it should never be entrusted to the patients themselves.

Hr. Senator could confirm the favourable action. With care on ill result need follow the applications. The painting over of a small surface was sufficient, and a repetition might be made over a different part. In every case the sweating ceased for days.

Hr. Stadelmann was not so pleased with it as he expected to be. In many cases the sweating ceased, but returned; other patients feel so bad that they begged not to have the treatment continued. Other antihydrotics sometimes acted when formalin had failed.

Hr. Ewald, although agreeing with the previous speaker, said that he should continue the investigation.

Hr. Albur read a paper on the

PHYSIOLOGY AND PATHOLOGY OF BILE SECRETION, in connection with the demonstration of a case of biliary fistula. It was remarkable that the patient (a female) was still rather fat. The fistula was two finger breadths below the right ribs. It led into a canal 10 to 11 cm. in length, passing backwards and upwards. Apparently there was an accessory passage provided with a receptaculum where bile could be temporarily collected. The patient was accustomed to let off the bile every two hours day and night; otherwise it trickled out persistently and was so disagreeable as to become unbearable. For this purpose she had had a fine canula made. The secreted fluid was quite clear, of a gold yellow colour, and was pure bile. Whilst having the case under observation for a year he had seen mucous flocculi only on a few occasions, and then only when the bile had been designedly kept back by plugs of lint or the like. It must be taken as certain that this bile did not pass through a bladder; apparently the patient no longer possessed a gall-bladder that could be felt. It was probable also that there was a biliary calculus, not

unlikely in the ductus choledochus. The bile had not changed its character during the period of observation; reaction neutral, sometimes slightly alkaline, sp. g. 1010 to 1012, the solid constituents from 5.9 to 2.5, which was characteristic of liver bile, bile from the gall-bladder containing 5 to 10 times as much solid material from absorption of water in the biliary passages. It was not a normal bile and the pathological processes going on in the liver sufficiently explained the deviation. The minimum quantity secreted was 327 cc.m., the maximum 498, the average being 400. This variation was remarkable, which, according to Stadelmann, also existed under normal conditions. The stools were generally absolutely alcoholic; several times they showed distinct colouration. No urobilin was found in the urine. Possibly a small quantity of bile escaped into the bowel when the pressure within the receptaculum was excessive. The daily period of freest secretion was about midday and midnight, the lowest secretion was always from four to six in the morning. Change of diet did not affect the secretion much. The patient herself thought she felt best with a vegetable diet, but the speaker did not consider the opinion reliable. He had tried the effects of the different cholagogues Carlsbad mineral waters, Carlsbad salts, hot and cold water, sodium salicylate, purified ox-gall, olive oil, glycerine, all with absolutely negative results, there could therefore be no question of any bile stimulating action of any of these substances. Moreover, in literature there was no sufficiently emphasised distinction between increased elimination of bile and increased formation. Laxatives and olive oil caused contraction not only of the bowels but also of the bile passages, and effected a more rapid flow of bile into the intestine. In cases of cholelithiasis with jaundice any action of cholagogues must be injurious, as the retained bile acids would be more driven backwards into the blood. In such cases the surgeon's knife was the only effectual remedy. Regarding the using up of fats in the intestinal canal, he had been surprised to find that of 100 grms 64 were absorbed, whilst in another case of closure of the ductus choledochus from carcinoma only 21 per cent. was absorbed. Both cases agreed remarkably as to the splitting up of fat as the pancreas of both patients was functionally active, it followed that the splitting up of fat was caused by intestinal bacteria. This explained the good condition of the patient, a normal individual absorbed 90 to 96 per cent. of the fat taken in. As regarded the supposed antiseptic action of bile in the intestinal canal, his investigation gave an absolutely negative result; they did not in the least confirm the view that the bile had any antiseptic action over the contents of the intestines.

Hr. Stadelmann did not look upon Albur's conclusions as reliable as he was not certain that the closure of the bile passage was complete.

Hr. Jacques Meyer pointed out that Carlsbad water could not act directly on the liver cells as a stimulant. We only had to do with an increase in the bile current, a consequence of peristaltic movements of intestine, further with favourably influencing any catarrh present in the biliary passages, inflammatory symptoms, &c., and amelioration in the morbid symptoms, but it caused increased rapidity of the bile current, and thereby a more rapid excretion of bile.

Hr. Rosenberg said that the present requirements of

a cholagogue had been altered; formerly it was expected to temporarily increase the quantity of bile by increased pressure or the removal of concretions. Now a man desires to increase the quantity excreted in the twenty-four hours, and we must be satisfied if the means employed raised the pressure and did so increase the quantity of excreted bile.

Hr. Alber, in reply, said that although he could not prove complete fistula, the absence of urobilin in the urine could be proved, and this he considered conclusive.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, April 8th, 1900.

PURULENT PERITONITIS.

At the Medical Club, Nossal brought forward a young man who had recovered from a case of purulent peritonitis. A few weeks ago he was taken suddenly ill with colic pains in the abdomen which gradually increased till collapse set in, when he was removed to hospital.

On admission the abdomen was greatly distended, percussion dull on both sides, but tympanitic in the middle; when the position was changed the percussion sounds were also changed. The diagnosis arrived at was: Perforation peritonitis, probably due to perityphlitis. From the hopeless moribund state of the patient all operation was abandoned as ineffectual. On the following night, contrary to expectation, the patient seemed better and like recovering! Dullness by this time had formed under the liver, which tended to increase upwards, and gave the impression of exudation.

An incision was made along the lower margin of the ribs, from which six litres of pus escaped. The patient recovered and is now perfectly well.

POLYNEURITIS AND SYPHILIS.

Ludwig Spitzer next showed a patient with polyneuritis, who, about the end of 1899, had a syphilitic eruption, which was first treated with potassium iodide, and later, with inunctions of mercury, but owing to the rapid toxic action of the drug, it had to be suspended. Later the drug was recommenced with the same result but aggravated this time with racking pains in the lower extremities. The movements became weak and ataxic with pronounced Romberg and knee phenomena. The question arose in the mind of Spitzer whether the disease was due to the mercurial treatment or some other morbid condition, but he was inclined to lean on the former as the most probable because the case has greatly improved since all specific treatment has been withdrawn.

AORTIC INSUFFICIENCY.

Schlesinger showed a patient with a peculiar movement of the head and neck from an insufficient aorta. At every pulsation of the heart the head moved forward as if by mechanical motion. There was also a lateral movement, and rising and sinking of the tongue and uvula. The walls of the pharynx were equally affected.

A PROPOSAL to establish a crematorium at Madrid has been brought before the municipality of that city, but, in spite of the advantages which this method of disposal of the dead offers from a sanitary point of view, the chances of its adoption are probably small indeed.

Continental Notes.

[FROM OUR SPECIAL CORRESPONDENT.]

THE AUSTRIAN TYROL.

RONCEGNO.

FROM the Trient Junction (on the main railway-line from Innsbruck to Italy), a branch railroad runs easterly, which, eventually, will connect Trient with Bassano and (via Padua) with Venice. This branch road takes a southerly sweep around Trient, and winding up a mountain side affords, as it ascends, varying and very picturesque views of the old city below with its walls, towers, steeples, domes, and palaces, and gives glimpses across and down the Adige valley of great beauty. It passes the historic Pergine chateau-palace, an ancient Pagan temple now dedicated to a Saint Ermetus, the lovely lake of Caldonazzo, the Levico Baths, and ruins of the Selva, Marter, and other castles. Nineteen miles from Trient is the Roncigno railway station; and half-an-hour's walk away, through the dark green of the pines and the brighter spring foliage of the chestnuts, may be seen the steeple and white houses of Roncigno village; on three sides surrounding and above the village on the lower slopes of the mountains are fruitful fields and vineyards, and forests of beeches, chestnuts and firs. A most verdant pleasant country-side. At noon the whole Brenta Valley comes into view, with the magnificent dolomites dividing it from Italy. A couple of miles distant down and astride of the Brenta river is the village of Borgo, and further off the vestiges of the Telvano and San Pietro castles, and the better preserved Ivano castle across the frontier. Morning and evening, shut in from Borea, and so sheltered from winds, Roncigno enjoys in summer a mild even temperature of 75°—81° Fabr., a most healthy climate, and very dry air. Visitors can very safely remain in the extensive park of the Roncigno Bath Establishment late in the evenings, when the atmosphere is fragrant with flowers and balsamic shrubs. Professor Faralli said, "in many cases Roncigno should be preferred to many other better known and celebrated European health resorts. Its climate is even and mild, the dryness of its pure air is remarkable, and East and West the mountains protect it from too strong winds."

Until the present proprietors, Messrs. Waiz Brothers, physicians, developed the place, Roncigno was utterly unknown as a health resort. They have erected a complete hydrotherapeutic establishment equipped with the latest scientific appliances. Annexed thereto they have an hotel, first class in all respects, with elegant dining, coffee, reading, conversation, and ball-rooms. Concerts are given daily; balls and festivities frequently. The handsome park is adorned with kiosks, grottoes, fountains, cascades, and every attention is given by the proprietors and their director to the comforts and amusements of their guests.

The mineral waters of Roncigno flow from springs on Mount Tesobo. They are natural and *unalterable* ferruginous, arsenical waters, combined with nickel, cobalt, and other sulphates. Dr. Spica in an able and exhaustive reports calls particular attention to the most important "physiological action of the salts of nickel and cobalt they contain; elements extremely rarely met

with elsewhere." He attributes the "powerful action," and "multiple beneficial effects," peculiar to the Roncegno waters to their unique combination of "arsenical compounds." The Roncegno waters are claimed to be especially efficacious for:

Anemia (whether combined with *Chlorosis* or not) accompanying growth, or derived from over-exertion, or from long and exhaustive illness, or consequent upon hæmorrhages.

Discrasia; special to lymphatic and scrofulous people, *fever*, and notably *Malaria*.

Cachexia; very successfully against any fevers which resist quinine and which periodical sequences.

Neurosis, *neurasthenia*, *hysteria*, *hypochondria*, *neuralgia*, internal or external, *nervous dyspepsia*.

Asthma, *catarrhal affections*, *eczema*, *goitre*, *earache*, &c.

For internal use: The initial doses are a teaspoonful for children, a dessertspoonful for young people, and a tablespoonful for adults at each meal. For external use: Roncegno water may be mixed with two-thirds of distilled water for gargles, colyrium, nasal douches, vaginal washes, enema, local and general baths. Also for disinfectants in treating wounds, fistula, &c.

"The season" for bathing at Roncegno is May 1st to October 1st; but May, June, and September are the preferable months.

The Operating Theatres.

WEST LONDON HOSPITAL.

ILEO-COLOSTOMY FOR MALIGNANT DISEASE OF THE CÆCUM.—Mr. BIDWELL operated on a man, æt. 36, who had been suffering from chronic obstruction for eighteen months. His first illness was two years ago, when he had been admitted to the hospital with a tumour in the region of the gall-bladder with jaundice. This had disappeared under treatment, and the patient remained in good health for six months. Then symptoms of chronic obstruction developed, and the patient began to emaciate. He was under the care of Dr. Ball in the hospital a year ago, the abdomen being distended, and peristaltic waves of contraction seen in the distended coils of intestine. The obstruction, however, was not complete, and he refused surgical operation. During the last year he had emaciated to a degree, and the griping pain had increased. He was then admitted under Dr. Seymour Taylor, who persuaded him to have something done. An incision was made in the upper part of the right linea semilunaris; a large tumour was found under the liver, this was easily brought out of the wound and proved to be a new growth involving the cæcum. The small intestine was enormously distended, being about twice the size of normal large intestine, the transverse colon was collapsed. There was a chain of glands in the meso-cæcum and meso-colon. It was decided to remove the growth in two stages, and on this first occasion to make a communication between the large and small intestine. An elastic drain tube was passed through the mesentery of the ileum about eight inches from the growth, and this was tied over the gut and fixed with artery forceps. The ileum was then held opposite the transverse colon about four inches from the growth, and eight Halsted's quilt sutures

passed uniting the two pieces of intestine; these were all tied and the corners of this posterior row of sutures united by three stitches on each side, which were also tied. A little beyond these twelve stitches, which constituted the anterior row and completed the oval, were passed, but not tied. These stitches were then drawn aside to make room for the knife, with which an opening was made into the approximated intestines; this opening was two inches in length. After securing the bleeding points in the walls of the gut the anterior row of sutures was tied, and the anastomosis thus completed. The elastic ligature was then removed from the ileum. The mesentery of the growth was next divided between ligatures so as to facilitate its removal on another occasion, and the enlarged glands were dissected out. It was then attempted to return into the abdominal cavity the part of the gut where the anastomosis had been effected, but it was found impossible to do this without returning the whole of the growth as well. This was therefore done after a piece of gauze drain had been passed round the tumour and through the hole in the divided meso-colon, in order to facilitate bringing out the growth again at a later date. The rest of the abdominal wound was closed. The patient had no bad effects from this operation. He passed a copious motion on the following day, and took solid food on the fourth day. On the ninth day he was again put under chloroform, and the abdominal wound reopened. Some suppuration had occurred in the neighbourhood of the gauze drain. The growth was brought out and, after clamping with a small elastic drain tube between the tumour and the anastomosis; the gut was divided on each side of the growth, and the tumour removed, each divided end of intestine was then united by layers of silk sutures, one of which included the mucous membrane only and the other the peritoneum and muscular and sub-mucous coats; a drainage tube and gauze drain were placed down to the sutured gut and the wound closed. Mr. Bidwell said that the long history of the case had pointed rather to some cicatricial contraction about the hepatic flexure due to the patient's previous gall-stone trouble than to malignant disease, and for this reason the incision was made in the upper part of the linea semilunaris. It was interesting, he thought, that the growth, although involving the cæcum, was found drawn up under the liver, the whole of the ascending colon being apparently absent. The reason he pointed out for doing the operation in two stages was to avoid shock, and to allow a sort of safety valve between the two portions until the anastomosis was soundly healed. In lateral anastomosis on the large intestine, he remarked, a very large opening is required between the two pieces of gut, but, provided this is done, the result is very satisfactory. The method employed was that of Halsted, which he always utilises for intestinal suture.

A MEDICAL student of St. George's Hospital, London, named Monro, was convicted of having stolen "marked" money from the pocket of a fellow student. Having been expelled from the hospital, his prospects for life ruined, the magistrate decided not to send him to prison, but to give him a chance of redeeming his character, and to come up for judgment if called upon.

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The Medical Press and Circular.

“SALUS POPULI SUPREMA LEX.”

WEDNESDAY, APRIL 11, 1900.

THE MIDWIVES BILL.

OWING to an extraordinary fall of luck to the promoters of this Bill it has reached a stage in Parliament which, we imagine, even its most sanguine advocates did not hope for. In the drawing of the ballot for priority of consideration, the Bill obtained a place which made it certain that its second reading would be debated, but when the day arrived the measure came fourth of a series of important and contentious Bills, and no one supposed that its discussion could be reached. Nevertheless, by the unexpected collapse of the other three Bills it got its chance, and, in the absence of any strongly organised opposition, it passed second reading, and was referred for amendment to the Grand Committee on Law, through which, notwithstanding its merciless dissection by opponents, it passed almost unchanged. It has now gone back to the report stage in the Commons, on which it can be again debated before it is sent to the Lords. Although the measure has been most fortunate in the position on the notice paper which it obtained, it is evident that it would have been passed by the present House of Commons at any time when a chance was afforded to it, for both in the House itself and in the Grand Committee it received the support of an overwhelming majority. The Radicals, headed by Mr. Atherly Jones, attended for the purpose of screeching for free trade in medical practice, and of abusing the doctors. Their platform was that “one man (or woman) is as good as another,” and that no check should be placed on unqualified practice by midwives or by any one else. As the Bill now stands, all existing midwives become duly registered practitioners of the speciality on producing “evidence . . . that, at the passing of the

Act, she has been in *bona fide* practice as a midwife,” and when existing midwives, by the lapse of time, dwindle in numbers every county council in England will become a licensing authority. The midwife so licensed is enjoined not to “attend cases of abnormal labour, or of disease of, or danger to the mother or the child,” without the assistance of a qualified medical practitioner, but, in fact, no such restriction will be operative because the Bill provides no penalty for its infraction, and it goes without saying that the midwife will treat the clause with well deserved contempt. The proposal to dub the newly-fledged hybrids “midwifery nurses” instead of midwives was rejected. It was pointed out in vain that medical men had been struck off the Register for employing unqualified assistants, and that the Committee ought to insist on the operations of these women being confined strictly to nursing. An amendment with a view to permit women practising in villages to style themselves midwives was rejected, so that after the passing of the Bill it will be an offence for any such women to use such a title unless registered. It will be open to them to call themselves Mrs. or Madame So-and-so, a state of affairs that reminds one of the evasive descriptions assumed at the present moment by unqualified dentists. The supporters of the Bill urged the opinion of the Medical Council, and of the Royal Colleges of Physicians and Surgeons that any measure which proposed merely to protect the name “midwife,” and which did not make penal the unlicensed practice of women for gain could not be regarded as containing a sufficient safeguard. The rejection of another amendment showed more than anything else in the proceedings the determination to run dead against the expressed feelings of the medical profession. This is the thin end of the wedge of unlicensed practice with a vengeance. The right of the Obstetrical Society to certify the new order of unqualified practitioners was confirmed. The absolute independence of the midwife to be recognised by the definition of midwife as “a woman who undertakes for reward to attend women in childbirth where no registered medical practitioner is engaged or employed.” The fact is that the profession has followed the example of other contestants by its three fruitless crossings of this Tugela. It has been coquetting with the midwives and has imperilled its game. The General Medical Council wasted itself in palavers with them, the British Medical Association never showed any earnestness or determination in opposing so calamitous and unnecessary a measure, while the London Obstetrical and its 4,000 midwifery nurses were untiring in their earwiggling of influential ladies and of those members of our profession who have been making money by the grant of these licences. Yet the campaign is not over. As amendments have been inserted by the Grand Committee the Bill must be discussed on the Report stage and, if it is vigorously fought, may be rejected or delayed. If not the opposition can be carried into the Lords and, considering the exigencies of the Parliamentary session we should be sanguine of its postponement until next year.

THE FUTURE OF ASYLUM SERVICE (DIETARY—SOCIAL ARRANGEMENTS).

[FOURTH ARTICLE.]

THE old-fashioned idea regarding meals was that what was good enough for pauper patients was good enough for attendants. The principle on which this idea was founded was this, that the patients ought to be treated to a liberal and variety dietary, and that it should be so good that attendants could not cavil at it. If for *pauper* we substitute *private* patients, that would be all right, and by *private* we mean patients paying a moderate rate of board; for the dietary of pauper patients in asylums was not always what it should have been in the years that are passed. There was a time not so long ago, and the MEDICAL PRESS AND CIRCULAR made strong remonstrances then, when the craze for running some English asylums on the cheap was not creditable to some superintendents who sank the medical man in the mere workhouse administrator, and have been largely responsible for the ill-concealed contempt with which medical men have till lately regarded asylum medical men and their work. This digression is by the way, but it is necessary as explaining the evolution of the practice which makes a distinction between patients' and attendants' dietaries. Where the attendants and nurses have their own separate mess-rooms the distinction may be expedient as well as necessary; but in asylums where the officials mess in presence of the patients the moral effect on the latter may be bad, and considerable suspicion, bad feeling, and excitement the result. The best opinion of to-day, however, is in favour of separate mess-rooms, and a great deal has been done of late years in catering for attendants and nurses. We have been told, and the statement is reasonably sound, that the more we do in this direction the more complaint prevails. Many attendants and nurses, especially the latter, and especially those from the most humble and precarious circumstances, are never satisfied. One such instance occurs to us, that of the ringleader in raising all such complaints, though he kept in the background when the deputation came face to face with the Superintendent. The more the grievances were considered, the more and more grievous did they appear, until at last, finding this man out as the real cause of malcontent, the Superintendent intimated that if there were any more unreasonable complaints he would receive a month's notice. Peace and harmony was the result. Every reasonable consideration should be given to this matter; but pandering to the individual hysterical idiosyncracies of some women should be absolutely avoided. It is not possible to cater to please all every day of the week, by reason of numbers, of prejudices, and dyspepsia, and it may be taken as a sound deduction from a careful and experienced consideration of the subject that a clean, wholesome, and reasonably varied dietary in sufficient quantity, without being meagre on the one hand as regards courses, &c., or extravagant on the other, is all that is required. Unless it really deficient and unvaried, changes on the

part of attendants or even nurses do not depend for their explanation on the dietary of an asylum. The social position, the relation to the outside world of the asylum attendant and nurse, are questions which have also come to the front. As a rule the nurse is better educated, and while some do marry attendants not a few look for something better. What will be said under this head applies more to the nurses. Their social position is decidedly superior to what it used to be, but what have they in the way of social amenities? It will be said that asylums are very jolly places because of the dances and concerts which are common there; but it is forgotten that the nurses at the dances and concerts are still in the asylum atmosphere, are still on duty, and surrounded by the insane. Much of this would be mitigated if they could have their own little parties when off duty, and in this direction, now that officials' recreation rooms are being provided, will asylum authorities look. The ideal treatment of nurses in this respect is to give them as much liberty as possible to go outside, to mix with their own people and friends in the same world, to go to concerts, theatres, dances, private parties, &c. There is, however, a "but." How many asylums are so happily situated near town, and with good travelling facilities to permit of this? There can be no question that such asylums possess an immense advantage in this respect over those which are isolated in "dead and alive" neighbourhoods, and the management and control of their staff is easier, and the contentment of the latter is more likely to be assured with a great deal less trouble. This fact points clearly to the necessity of removing the disparity in the amenities of the two classes of asylums, and though it means extra trouble and perhaps expense, it means that the principal asylum officials must give more and more consideration to the question how best can we socially compensate our country staff for the want of privileges which those in town enjoy? Far more important is this question than the chimera of an eight hours' day. It is well for the moral and mental well-being of the staff and reflectively of the patients.

THE ETIOLOGY OF CANCER.

ALTHOUGH our knowledge of the subject of the etiology of cancer is undeniably increasing, it cannot be said as yet that we have been able to determine what cancer is. There is nothing else then to be done than to continue to "peg away," speculating, investigating and experimenting, in the hope that some day something definite will be evolved out of the obscurity of the disease. Almost every country in the world has a certain number of experienced bacteriologists who are devoting much time and thought to special investigations into the subject of cancer, and particular mention in this regard may be made of Germany, Italy, America and Japan. A valuable contribution to the etiology of the disease, for example, has just been brought before the New York Academy of Medicine, consisting of a

full report of the work of the past year in the New York State Laboratory for the investigation of the cause of cancer. One of the most interesting features of this report is the record of the results of the cultivation experiments. The enterprise of the investigators led them to attempt every kind of cultivation which could be suggested. Altogether 1,200 cultures were carried out on sixty different culture media. But only once was inoculation successful. Nothing could show plainer than this the difficulty of the subject. The more extensive the field of inquiry becomes the more insoluble does the cancer problem appear. Rarely, something occurs which seems to give promise of definite progress, as, for example, the experimental inoculation of cancer to a rat. But beyond this single success, concerning the cause of which nothing is known, all inoculation experiments have practically failed. Nevertheless, many cases have been recorded of cancer infection in individuals. We know, for instance, that one vocal cord may infect the other, that epithelioma of the labium on one side may be followed by the development of the disease on the other, that cancer of the stomach may occur from the infection of portions of cancerous tissue detached from carcinomatous disease of the œsophagus and swallowed. Thus the inference is that a particular condition of the blood and tissues must be present before cancerous growths can develop, and that, unless the soil be prepared, the disease will not declare itself. Perhaps the failure of inoculation experiments may be explained in this way, and it may be that this preparation of the soil has a great deal more to do with the evolution of cancer than has hitherto been supposed. Quite possibly it forms the key to the cancer problem. If, in short, we were cognisant of the conditions which predisposed to cancer, that is to say, if we could only ascertain the causes which led to the soil being prepared, it would probably be an easy matter to deal with the disease. The micro-organism of cancer is probably just as ubiquitous as the bacillus of tubercle; but the tubercle bacillus can only become active when it alights upon suitable soil, and in all probability the same is true with respect to cancer. In the near future we shall no doubt find the prevention of tuberculosis largely effected by taking measures to suppress the causes which predispose to its infection. In discussing this part of the subject reference may be made to the fact that there is undoubtedly a pre-cancerous stage of cancer as there is a pre-tuberculous stage of tuberculosis. In each case certain indications are present which foreshadow the development of cancer on the one hand, and tuberculosis on the other. Nothing so far, however, has been determined in regard to the pre-cancerous stage of cancer which has proved helpful in explaining the etiology of the disease.

It is announced that no meeting of the Royal Medical and Chirurgical Society will be held during the month of April, by order of the Council.

Notes on Current Topics.

School Diphtheria and Ringworm.

THE great rise in diphtheria mortality during recent years continues to vex the spirit of the zealous sanitarian. There can be little reasonable doubt that the antecedent condition which accounts for the increase is the introduction of the board school system, whereby the major part of the juvenile population is daily brought into close contact one with the other during the greater part of the year. The special danger in such communities is due to the early and undetected cases of diphtheria which are regarded simply as sore throats, and often receive no treatment whatever. No scheme of public schooling can be considered sound if it does not provide for the exclusion of infection and contagious diseases, such as measles, scarlet fever, diphtheria, and ringworm. The only means of securing such a desirable end appears to be by frequent and systematic medical inspection of all board school children. So far as diphtheria is concerned, all the scholars suffering from sore-throats could be at once quarantined until a bacteriological examination decided the question one way or the other. This question of the medical superintendence of our board schools must come to the front somewhere in the near future, for the present muddle simply plants hotbeds for the circulation of zymotic diseases broadcast through the length and breadth of the United Kingdom. London, with its teeming population, has practically no medical supervision over the health of board school children. Take the single instance of ringworm which runs riot in these institutions. It is a chronic and disgusting malady, highly infectious and extremely difficult to cure, yet a glance at the children coming out of an average board school will reveal the fact that a great many of them are suffering from this preventable complaint.

Chemical Preservatives in Food.

The *Therapeutic Gazette*, discussing the use of chemical preservatives of food, observes that it would be difficult to find any valid reason for the presence of salicylic acid or other special preservative in such articles of food as jam, cheese, and pickle, whilst the use of certain preservatives as substitutes for alcohol is a matter of fraud pure and simple. So also the use of a tasteless preservative in butter cannot be regarded as other than fraudulent unless the fact is declared; by using such a preservative the vendor is enabled to sell as fresh butter what under former conditions would have been sold at a lower price as salt butter. The use of boric acid, again, for salting bacon and ham may or may not cause injury to the consumer, but in any case the latter should have the opportunity of exercising his own judgment on the matter as to whether he will eat that class of preserved food. The necessity for legislation on this subject lies in the fact that these preservatives are, in the quantities used, tasteless, and cannot be detected by the con-

sumer. If, for instance, a preserved milk could be distinguished from fresh milk as readily as salted beef can be distinguished from fresh beef, no necessity for legislation would arise. The consumer would know exactly the kind of article that he was buying, and there the matter would end. There would then be no more reason for prohibiting the sale of preserved meat than there would be for prohibiting the sale of salted beef on the ground that the latter was not suitable for making beef tea for invalid diet. But since the public have no means of distinguishing between a fresh and a preserved milk, special legislation does seem absolutely necessary. And such legislation, to satisfy the requirements of the public health, should provide that no preservative whatever, the use of which is not sanctioned by the Local Government Board or the Board of Agriculture, should be used for milk, that the proportion of such preservative should not exceed a certain maximum amount to be fixed officially; that the nature of the milk should be declared by the vendor; and that it should be sold only as "preserved milk. And finally, the penalties for infringement of the law should be sufficiently heavy to render the sale of preserved milk as fresh milk unprofitable.

Small-pox and the English Local Government Board.

It is, of course, necessary for the Local Government Board to adopt guiding rules and principles, but at the same time a certain amount of elasticity in their application is clearly desirable. An instance of hardship that an iron-bound regulation may reflect upon a particular community has recently been reported from Portsmouth. The Corporation of that town, having received a warning to provide a small-pox hospital, purchased six acres of land at a cost of £3,000 in rear of existing Infectious Diseases Hospital. Upon that site they proposed to erect small-pox wards, but the necessary approval of the Local Government Board was withheld upon the ground that such a hospital must be at least half a mile away from any other building. Now it so happens, according to the *Hampshire Telegraph*, that there is not a single spot of land in the borough that would meet the official requirement, and the Corporation are naturally somewhat puzzled as to how the difficulty is to be solved. Perhaps the best plan would be to buy an obsolete warship from the Admiralty and moor it somewhere out in the harbour. The reason for the Local Government Board regulation appears to be founded upon an adherence to the theory of the aerial distribution of small-pox. If so, that body has pinned its faith to a theory that has never been scientifically demonstrated. Indeed, the balance of evidence points in the other direction, namely, that small-pox is spread almost invariably by personal agencies, although in many instances the links of the chain of communication may be difficult to trace. Meanwhile it is evident that the "hard case" of Portsmouth will have to be met in some way or other so that the citizens may have their small-pox hospital.

Gonorrhœa and Syphilis in regard to Sickness and Life Insurance.

THE history of an attack of syphilis in the antecedents of a person wishing to insure his life or to make some provision against sickness is always regarded as a detail of considerable importance in estimating the value of the proposal, while, on the other hand, not much stress is laid upon episodes of gonorrhœal origin. It is, however, open to question which of the two diseases is most fraught with detrimental results in respect of life and health. Syphilis, it is true, is credited with an alarming array of pathogenic possibilities, but in the great majority of instances if it has been properly treated, the sword of Damocles does not fall, and life may run its normal course. In gonorrhœa, however, more or less intense prostatic irritation occurs in a tangible proportion of cases, and more or less pronounced narrowing of the urethra is another complication which claims a comparatively large share of victims among the sufferers. If we reflect upon the grave consequences of these lesions on the future health, and even life, of the afflicted ones, we may be tempted to ask whether after all gonorrhœa is not, in the aggregate, more serious in its ultimate consequences than the much-dreaded syphilis, and consequently more deserving of attention at the hands of examining physicians. It may be asserted with some show of reason that if syphilis is more menacing from a sickness point of view, gonorrhœa, in virtue of its secondary and far-reaching effects on the urinary tract, is more dangerous to life. The question is one which can only be decided by reference to statistics bearing on the frequency of complications and sequelæ, but, unfortunately, no such statistics are available for the purpose, and each surgeon is fain to draw approximate conclusions based on his own experience. It is certainly a mistake to regard gonorrhœa as a necessarily benign disease, for the frequency of one or other of its many complications renders it potentially grave. A cured uncomplicated attack of gonorrhœa is doubtless a detail of no particular pathological significance, but it behoves practitioners entrusted with the responsible duty of examining candidates for life or sickness insurance to bear these possibilities in mind in arriving at a conclusion.

The Care of the Hair.

THE care of the hair is not a subject in which the average person receives any definite instruction. By some it is regarded as unworthy of attention until it is too late to take it in hand, while others go through the routine of brushing, curling, and washing without a thought for the morrow. Dr. G. T. Jackson, of New York, has kindly undertaken to enlighten our ignorance in respect of many points concerning the treatment of the hair. Obviously it is important to know how often we ought to wash our heads. This must, of course, depend to some extent upon circumstances, but Dr. Jackson opines that once a month is sufficient for ordinary purposes, and he distinctly discountenances "daily sousing of the hair." He does

not object to the use of soap, on condition that it is well washed out afterwards. A more important question is that which concerns the use of pomades to the hair. There has been a great reaction from the one-time fashion of belarding the scalp with some fatty body, and nowadays it is the custom to discard all greasy applications altogether. In this respect Dr. Jackson believes that the pendulum of fashion has swung too far. He premises that precocious baldness is far more common at present than of yore when the hair was neatly plastered down and kept shiny by the aid of some pet pomade, and he is disposed to attribute youthful alopecia to the practice of wetting the hair in order to get it to "lie" and to the disuse of fatty bases. Fortunately the author does not impose any restrictions on getting one's hair cut, and he gracefully concedes that this is solely a matter of taste. At the same time he believes that feminine beauty will best be fostered by not cutting girls' hair after they have reached the age of ten or twelve, in order to favour the development of its natural silkiness. The only thing Dr. Jackson really gets angry about is what he terms "that most ludicrous practice" of singeing the hair, and courage fails us to join issues with him in his tirade against a practice which is perhaps more honoured in the breach than in the observance.

The Notification of Phthisis in Manchester.

THE report of the Medical Officer of Health for Manchester on the working of the system of voluntary notification of phthisis introduced in September, 1899, is interesting and instructive reading. The report shows that the total number of notifications received from September 11th, 1899, to March 17th last was 826. Of these 533 cases were notified between the former date and February 3rd, and 293 cases between February 5th and March 17th. Since February 5th more than half the notifications have been sent by medical men in private practice, and that the number of houses visited was 680. So far no objection has been made to these visits either by the patients or by their medical attendants, but some of the patients have expressed their satisfaction that more active measures are being taken by the corporation to combat the disease. Recently it has been found impossible to make the visits keep pace with the notifications, and there are 146 cases still waiting to be visited. The original scheme contemplated the appointment of three medical inspectors, and a second is now about to be selected. Obviously if such a scheme is to yield practical results it must entail an enormous amount of labour, *inter alia* in regard to the bacteriological result of milk and other articles of food. Every credit is due to the municipality for having had the intelligence and the courage to set an example in this direction, an example which will, sooner or later, be extensively followed.

It is reported that seventy cases of plague have occurred at Sydney with twenty deaths, and that the quarantine area has been further extended.

Local Death-Rates.

THE mortality returns of the Registrar-General for the United Kingdom furnish most instructive reading, and are specially reassuring in their record of steady decrease of the national death toll almost year by year. That improvement has been more conspicuous since the passing of the Public Health Act of 1875, which may be called the corner stone of the modern preventive edifice. The returns for the whole kingdom, however, show a difference when sub-divided into countries, and still more so when further cut up into counties. Carrying the analysis still onward, an enormous disproportionate mortality becomes apparent between different towns. The towns themselves exhibit almost as great variations when taken in districts, when it is not uncommon to find one area with a death-rate of thirteen and another of thirty per thousand of population living. Even when we have reached this point there is a further dilution to be discovered, for even in the bad districts there are deeper depths in the shape of plague-spots where the mortality reaches the appalling figure of forty per thousand of adult and fifty or sixty of infantile population. If these death-dealing sums were excised all over the kingdom there would undoubtedly result a great general improvement in the national health as registered by the yearly mortality. A notable example in this direction has been set by the London County Council, whose good work may well encourage other urban authorities to purge their districts of bad areas, and to take every advantage of the powers conferred by the Housing of the Working Classes Act.

Electricity and Alcoholism.

THE mind of man is a curious study, seeking as he ever is to pry into the heart of things upon insufficient data. There can be no doubt, broadly speaking, that he himself is greatly influenced by the reaction of his emotional temperament to conditions of external environment. The views lately advanced by various greater or lesser scientific authorities, however, upon the relation of drunkenness to climatic conditions will strike the average investigator of such problems as bordering on the grotesque. Dr. Schliep, of Baden-Baden, has recently published a general statement of opinion to the effect that mankind is stimulated when he is in a state of positive electrification and depressed when negatively charged. In the former condition he is elated, feels well and his bodily machinery works at its best, whereas in the latter he suffers from all kinds of maladies, from biliousness to apoplexy, he is open to septic invasions, and becomes the prey to lassitude and takes to drink. That many persons are sensitive to the electrical conditions of the atmosphere few medical men would attempt to gainsay. At the same time they would undoubtedly reject as a class any particular conclusions of the kind indicated. The question of temperance is one of individual control against any kind of temptation, and persons of weak control would drink

whatever the state of the weather, wet, fine, hail, snow, sleet, or thunder. If Dr. Schliep's theory were correct publicans would need a new electrical barometer, and some means would have to be devised for reversing the negatively electrified condition of those of our citizens who are not total abstainers.

Sanitation in the City of London.

ON the whole, the sanitary management of the City of London proper may be regarded as one of the best in the world. It is carried out systematically under an able Medical Officer of Health, who has abundant administrative resources at his disposal. At the same time, there is reason to think that room for improvement still exists in various parts of an enormously important area that falls under the control of the City Corporation. The dangers to which we allude arise from the grafting of modern upon ancient methods of dealing with sewage. From facts that have been brought to our knowledge by a correspondent, a great number of untrapped and unventilated drain and soil pipes exist even in palatial buildings erected within a comparatively recent date. One of the most deadly of all these dangers, however, is to be found in the cesspools that still underlie many houses in the City. Incredible as it may seem, there are busy restaurants where the whole of the sewage runs into cesspools beneath the customers' feet. As might be expected the barmaids who pass their working day over these death traps are for the most part in a state of profound anaemia and chronic ill-health. We gather that more than one such restaurant exists in the City, and very possibly further inquiry would show that the evil is not exceptional, as one would hope. Clearly the only way to ascertain the existence of sanitary defects of so serious a kind as those suggested by our correspondent is to institute a rigorous house-to-house inquiry into the individual house drainage systems of the whole area. If the average citizen were told that in the year of Grace 1900 he ran the risk of lunching or dining over a cesspool he would simply refuse to believe that such a thing could be. However, now that attention has been drawn to the possibility, it is to be hoped that some authoritative statement may be forthcoming upon the matter.

The Pathology of the Paris Exhibition.

THE French Government has taken a wise step in providing facilities for revaccination of the population of the home departments in view of the afflux of people from all corners of the world which the opening of the Exhibition will determine, the more so as the population in general is very imperfectly protected against small-pox. A carefully compiled record of the perturbations produced in the sickness and death-rates of Paris during, and for some months subsequent to, this Exhibition would be interesting reading, especially in regard to the prevalence of infectious diseases. If, on the one hand, the visitors from afar bring their quota of disease, many of them take away with them the germs of disease contracted during their stay in the gay but

from many points of view, unsanitated metropolis. Gonorrhoea, syphilis, and typhoid fever are the three principal diseases which afflict the foreign visitor, and while the first two named can easily be avoided, it is less easy to ensure immunity from typhoid fever. Visitors to Paris should be strongly urged to make use for drinking purposes exclusively of mineral waters, and on no account to use the unfiltered water of doubtful purity which is supplied in hotels, restaurants, and cafés.

The Royal College of Physicians, London.

ON the day following Palm Sunday, the most important meeting of the Fellows of the Royal College of Physicians is held for the election of President and for a general statement being made of the past year. It is usual for the President to give some biographical account of the Fellows who have passed away in the year. Among the best known were Sir William Roberts, Rev. Dr. Hicks (Bishop of Bloemfontein), and Sir R. Thorne Thorne. One of the questions for consideration was the election of a representative of the College at the University of London, and some difference in this election seemed to be desirable, as the Council were of opinion that the selection should not be left to them, but that the whole body of Fellows should take interest and part in it. Dr. Selby Church was re-elected to the presidency almost unanimously. The meeting of the college was not a very full one, the number of Fellows present being about one-third of the total. An example is being set by some of the Fellows in contributing either by donation or by legacy to the funds of the College, which are not in as satisfactory state as could be wished. The large silver bowl containing new half-crowns in small envelopes was carried round by Dr. Theodore Williams, the junior censor, and the gravity of the meeting was thus relieved of its serious and rather solemn character by this ancient custom. If it is decided that a representative of the country should attend at the meeting to be held in Naples this month to discuss questions connected with tuberculosis, it is probable that Dr. Charles, of Rome, will be requested to fill this post. It was gratifying to the Fellows to hear that a telegram had been sent to H.R.H. the Prince of Wales, who was elected an Honorary Fellow of the College last year expressing in feeling terms the congratulations of the College on his happy escape at Brussels from the attempt made upon his life.

Joint Stock Doctoring Companies.

WE have already explained to our readers that the profession is seriously threatened with an invasion by unqualified persons who may form companies to practise medicine, surgery, and midwifery, as the co-operative stores practise pharmacy, under the cloak of a single qualified man. The Companies Bill now before the Commons contains a clause which would prohibit this; but, as it has been stated that there is a danger of that clause being withdrawn in deference to the jealousy of the chemists, who are not given the

benefit of a similar proviso, the representatives of the profession are taking steps to prevent the withdrawal of the clause. The President and Council of the Royal College of Surgeons in Ireland have forwarded the following petition to Mr. J. H. Campbell, Q.C., M.P., for presentation to Parliament:—

"That your petitioners have carefully considered the terms of the Companies Acts Amendment Bill so far as they affect the practice of Medicine, Surgery, Dentistry, and Midwifery in this kingdom, and are of opinion that it is very necessary, in the public interest, to safeguard the practice of the profession by preventing its being carried on by persons who have not undergone the requisite medical education or proved their competency by obtaining a degree or diploma recognised for that purpose.

"That it has been recently proposed that companies of unqualified persons shall carry on such practice, and your petitioners humbly pray your Honourable House to refuse its consent to such a proceeding by passing the third clause of the said Bill without alteration.

The Pay of the South African Medical Staff.

In the House of Commons last week the Under-Secretary for War produced some interesting figures respecting the emoluments of the medical officers serving with the Army. He stated that the top salary for one of the regular staff is £1,572 yearly, and the lowest salary is £336. The civil surgeons on duty with the forces receive £429, and the consulting surgeons, such as Sir William MacCormac, Sir William Stokes, and Sir William Thomson, £5,000 a year each. The demand by the profession for employment on these terms is excessive, no less than 3,000 applications for appointment having been sent in. In the nursing service there are 514 nurses who receive £30 a year and allowances in permanently engaged, or £2 2s. if per week if sent home with invalid or on other temporary duty.

Death of the Dublin City Coroner.

THE unexpected death of Dr. Joseph E. Kenny, the Coroner of the City of Dublin, was announced on last Monday, he having been ailing, but not very ill, for some days previously. He took his first qualification as L.A.H. in 1868, and the diplomas of both Irish Colleges in 1870, after which he served for a long period as medical officer to a city dispensary and to the North Dublin Union. Subsequently he was appointed coroner, and has held that office for many years. Dr. Kenny was a strongly militant politician and a staunch follower of Mr. Parnell, while he sat for one of the divisions of the City of Dublin, but he retired from the senate a few years since. The office which he vacates is worth £500 a year and is in the gift of the Dublin Corporation.

The City of Dublin Hospital.

THE foundation stone of the new wing, which is about to be added to the hospital for the accommodation of the nursing staff, was laid on Monday last by the Princess Christian, who was accompanied by her Excellency the Countess Cadogan, and was received by a distinguished company. It will be recollected that we recently stated that the Governors

of the hospital had decided to terminate the arrangement with the Baggot Street Nurse's Home, which has hitherto contracted for the nursing of the institution, and it has now taken upon itself the sole management of this department.

What's in a Name?

THE Russian Government, having observed that a nostrum was largely advertised and sold for the cure of asthma under the name of "Ephedra Vulgaris" at about half-a-guinea a pound, caused it to be examined, and found it to be nothing more nor less than finely chopped hay.

The Metric System.

THE Russian Minister of Finance has tabled a project of law intended to make the metric system compulsory in all business transactions in that country. Since 1896 it has been in use in the Russian pharmacopœia.

SINCE the opening of the London School of Tropical Medicine in October of last year, fifty-two students have gone through the course of instruction there, the majority of them being medical officers attached to the army, navy, or colonial services, though there was a sprinkling of private students among the number, including six medical women.

A PASTEUR INSTITUTE was opened last week at Antanarivo, the capital of Madagascar, so that even the inhabitants of this distant isle will, in future, be enabled to avail themselves of the progress of preventive and curative medicine.

PERSONAL.

DR. G. T. BRATSON has been appointed surgeon to the Glasgow Western Infirmary, *vice* Professor Buchanan.

LORD MANSFIELD has accepted the chairmanship of the City Orthopædic Hospital, *vice* the Earl of Aberdeen, resigned.

DR. ROBERT BARNES has been elected Vice-President of the Board of Governors of the Seamen's Hospital Society (Dreadnought Hospital).

WE regret to learn that Sir Wm. J. Priestley, M.D., M.P., is lying seriously ill at his London residence, and that grave fears are entertained as to his recovery.

DR. W. SELBY CHURCH was unanimously re-elected President of the Royal College of Physicians, London, at the annual general meeting of Fellows on Monday last.

DR. MOTT, the able pathologist of the London County Council, has had his salary raised from £700 to £1,000 per annum, a pleasing tribute to their appreciation of his work.

THE Archbishop of Montreal is credited with the intention of founding a chair of "medical theology," whatever that may be, in connection with the Laval University.

DR. W. J. COLLINS was elected leader of the Progressive party on the London County Council, but has been obliged to decline the honour owing to the demands of professional work.

MR. L. R. BRAITHWAITE, of the Yorkshire College of Medicine, Leeds, and Mr. A. G. Christian, of Owens College, Manchester, have been awarded the Victoria University Scholarship.

MR. B. MOORE, M.A., Professor of Physiology at Sheffield Medical School, Yale University, U.S.A., late Assistant Professor of Physiology, University College, London, has been appointed Lecturer on Physiology at the Charing Cross Hospital Medical School.

PROFESSOR SCHENK, who achieved notoriety if not fame by the publication of his ill-matured views on a method of regulating the sex of infants, has had to resign his chair in the University of Vienna, and he proposes, we are told, to betake himself to America.

THE Senate of the Royal University in Ireland has passed a grace to confer upon Sir James Reid the Honorary Doctorate in Medicine of the University. He is Resident Physician and Physician in Ordinary to the Queen, and holds the highest available professional distinctions.

THE funeral of Sir Douglas MacLagan, whose obituary will be found in another column, was attended on Monday by the Senatus of the University of Edinburgh, representatives of the Royal College of Physicians and Surgeons, and other public bodies. Among the pall-bearers was Dr. MacLagan, now Archbishop of York, brother of the deceased professor.

Special Article.

THE PROFESSION AND ITS GUARDIANS.—THE MIDWIVES BILL.

THE important meeting which was held at the Cannon Street Hotel on Wednesday last to consider and adopt measures to resist the passage of the present Bill for the Registration of Midwives through Parliament is specially worthy of notice. The room in which the meeting was held was full, some ninety members of the profession from South-East London and the adjacent parts of Kent and Surrey being present. The points which have been so often urged against previous bills, and which are advanced with equal justice against the present one, were well put by Mr. George Brown, as one of the direct representatives, who occupied the chair. The want of all those safeguards which the profession, as a body, demands that any Bill providing for the registration of midwives or nurses should possess, are as prominently absent from the present Bill as from its predecessors. In its disregard of the statutory rights of the profession by the creation of a new class of persons licensed to practice an important branch of the profession without sufficient guarantees of restriction; in its inefficient provision for the education of those who are thus licensed; in the inadequate nature of the safeguards that it con-

tains for the safety of a woman who may in emergency require the educated and skilled assistance of the qualified obstetrician; in the obvious ignorance which all through is apparent of the commonly occurring difficulties in labour which are met with often at the outset of a case, and on the efficient meeting of which the life both of mother and child depends; in the mixed character of the medical and lay elements that will form Courts of Appeal and have to exercise jurisdiction under the provisions of the Bill, in these and in many other particulars the Bill now before Parliament, in the eyes of the vast majority of the profession, is an obnoxious measure, and utterly fails to provide those essential safeguards for the public that, if we disregard altogether the rights and interests of medical practitioners, it ought to possess. The chairman claimed that the profession did not maintain that legislation was unnecessary. On the contrary, it was considered that some legislation was needed, but not of the jumbled nature that this Bill provided. Its promoters have been active, while the majority of the rank and file of those whose rights are threatened by its clauses have been apathetic, and the profession must lay the blame at its own door for the indifference and apathy that required the plebiscite of a contemporary to ascertain what its feelings and wishes on the matter were. It is late when a grand committee of the House has reported on a Bill to consider measures to resist it.

There are other expressions of opinion, however, elicited at this meeting which to those members of the House of Commons who were present, and to those of the public who may read the proceedings, must appear both strange and inexplicable. Here was a highly respectable and representative gathering of medical practitioners from the part of the metropolis in which it was held. Yet when Mr. Penn, the member for Lewisham, appealed to the meeting for information on the point as to whether the Bill had the approval of the General Medical Council, there were cries of "No, no," and "Yes, yee," and when he further asked if the Bill had the approval of the Royal Colleges of Physicians and Surgeons, there were loud replies in the negative.

Mr. Penn, naturally, as he said, attached considerable weight to such approval, and pointed out how the statement that it had been given to the Bill had already influenced, and would affect the House of Commons:—"Where men had not enough technical knowledge to judge of the value of those bodies." The statement was met with cries of "Close Boroughs and Corporations!" and so strong was the feeling elicited that Mr. Penn concluded by saying "that evidently the opinion of these bodies did not carry the amount of weight that had been attached to it," which view was energetically cheered by the meeting. Subsequently, Dr. Mytyle, the Mayor of Harrogate, after stating that the General Medical Council did not give its consent to the Bill, accounted for that of the Colleges of Physicians and Surgeons being obtained by the fact that the aims, objects, and wants of "general practitioners were not considered" by these colleges.

We think it unfortunate that at a later part of the proceedings a resolution should have been carried in the absence of Dr. Glover, and when many of those who might have objected to it had left, calling upon him to resign his position as a direct representative in con-

sequence of his "lukewarmness," or as seemed to those who voted for the resolution, his partial support of the present Bill. It were better that such action were not taken hastily, and without consideration, or without affording Dr. Glover an opportunity of fully explaining his attitude in regard to the measure. The meeting, however, had made up its mind that the General Medical Council had "signally failed to amend the worst provisions" of the Bill before Parliament.

It surely is a strange and deplorable fact that there should be such an utter divergence of opinion between those who are supposed to guard the rights and privileges of a great profession, and to furnish the link which binds it to the State in all matters relating to the safety of the public, and the ranks of those who compose what Professor Clifford Albutt once well called "the robust general practitioners." Still more is this to be regretted when this utter want of touch and common sympathy is made apparent on a question so important as the one now at issue, and which must have a permanent and appreciable effect upon those who are now in, or will hereafter join the ranks of medicine. It does look like a case of "the blind leading the blind," with, so far as the present Midwife's Bill is concerned, the probable result which such an experiment generally entails. It is sad to have to record the proceedings of such a meeting as that held at the Cannon Street Hotel, at which such an utter want of confidence in their leaders was expressed by those who attended it, indicating a degree of suspicion and distrust that it is not to be wondered at that the House of Commons, as in the instance of the member for Lewisham, should fail to understand what the real feeling is with regard to the Bill.

The applause which greeted Mr. Foster, the member for West Kent, when he said that, speaking for himself and for his wife, whom he had consulted on this subject, what he would like to see established would be trained nurses, subject to, and not independent of, the supervision of proper Medical Officers, voiced, we feel confident, the widely-prevalent feeling of the profession on the entire matter.

FRIENDLY SOCIETIES AND MEDICAL FEES.

At a special general meeting of the Wood Green and District Medical Society, held on April 4th, 1900, the following resolutions were unanimously adopted:—

I. That the Wood Green and District Medical Society, having carefully considered the present and proposed new rules of the National Deposit Friendly Society, Limited, consider that, to make that Society one which it can recommend to the profession, it shall alter its rules as regards medical pay as follows:—

(a) That each intermediate visit in dangerous cases shall be paid for at 2s. 6d. per visit.

(b) That the removal of cancerous or other tumours of magnitude shall be paid for at the rate of £5 instead of £3.

(c) That there shall be a minimum fee for attendance in midwifery cases as follows:—

I.—For patients drawing up to 3s. per day sick pay, ordinary labour, £1 1s.

Instrumental labour or cases of version, £1 11s. 6d. (major operations excepted.)

Where anæsthetic is used, 10s. 6d. extra to above fees.

II.—For patients drawing from 3s. to 5s. per day, 10s. 6d. extra to above fees.

III.—For patients drawing over 5s. per day, £1 1s. extra to above fees.

Also that such fees shall be paid by the society direct

to the medical attendant and deducted from patient's "sick pay," or "deposit" if sick pay be insufficient.

(d) That the fee to be paid by all candidates for admission shall be at least 2s. 6d. for their medical certificate for entry.

2. That there is no reason why "Medical Officers" should be appointed for districts, inasmuch as all registered medical practitioners are eligible to attend members and sign all certificates, and that by appointing a particular medical man as Medical Officer he is given an undue preference over other practitioners, as evidenced in proposed new rules (IV. Sec 6; Rule XIV. sec 14)

3. That the certificate of health of candidate for admission shall be sent direct to the District Secretary, and not returned to the candidate.

4. That the patient may obtain the advice of a consulting surgeon upon the same terms as proposed in the new rule (Rule XVI. Sec. 14, Sub-Sec. 5).

5. That no member shall be eligible for medical pay at above rates (Rule XVI, Sec. 14, Sub-Sec. 1, 2, 3, 4, 5) whose average income exceeds £5 per week.

6. That copies of the above resolutions be sent to the medical press, the Ilford Medical Society, and the East Suburban Medical Protection and Medico-Ethical Society, Ltd.

Scotland.

[FROM OUR OWN CORRESPONDENT.]

THE REGISTRAR-GENERAL OF SCOTLAND'S REPORT FOR 1899.—The figures issued from the office of the Registrar-General of Scotland for last year possess several points of interest. To begin with, the number of births in relation to the total population—28 per 10,000 below the rate for 1898, and about 20 per 10,000 below the average for the ten years from 1889-1899, showing a slight decrease in the general birth-rate—has to be contrasted with the marked increase in the number of marriages registered from 1893 progressively onwards. The actual rate for 1899, in fact, has only once been exceeded, i.e., in 1873, when the rate per 10,000 was 77.73, as compared with 76.92 for last year. The death-rate of 1899, though slightly over that of 1898, shows favourably when considered along with former averages, and only five of the last 34 years afford a smaller figure. A fact of some interest relates to the seasonal incidence of death. While of the last eleven years the rates of mortality during the first two quarters of these years have varied little, the rate during the third quarter has appreciably increased; that of the last quarter even more markedly decreased. Associated with this it may be noted that the mean temperatures for the quarters of the first five years of the series, 1889-1893, and of the last six, 1894-1899, give very similar figures in the case of the first two quarters. While the third and fourth quarters of the second series of years present increases equal to 0.9° and 1.0° Fahr. in mean temperature. Increased warmth, therefore, during late summer and early autumn apparently has conduced to raise the death-rate; during the last three months of the year to a fall in the mortality figures. Further, if the figures for the five warmest autumn quarters be taken and averaged, and those for the six colder ones, the first with a mean temperature of 53.51 Fahr., the second set 54.8°, the respective mean death rates work out at 1.73 and 1.56 per cent., or a large excess comparatively, during the warmer months. On the contrary, the means for the five warmer and the six colder fourth quarters give temperatures of 43.48° and 41.03°, with mean death-rates of 1.77 and 1.91 per cent., the exact opposite of the former quarters' values. Similarly in the first quarter the mean death-rate is less in the warmer years. In the second quarter little difference is shown. The geographical differences in the ratio of illegitimate to legitimate births during 1899 serve to stigmatise the same districts that have for so many years been notorious in this respect. Referring to the Report for 1885 the county of Banff comes first with 17.1 per cent, Wigtown

next with 15.8, closely followed by Dumfries with 15.3 per cent. The counties more or less closely approximating to these figures are all closely connected geographically with them, save for Kinrosshire. Now, in 1899 Wigtonshire is an easy first with 14.1 per cent., Banff second with 13.4 per cent., the adjoining counties showing slightly smaller rates; while Kinross has risen to near the top of the scale in inverse proportion, 13.2 per cent. in 1885 being replaced by 4.6 per cent. in 1899. It is a notable fact that the counties in the southern and north-eastern districts of Scotland should so persistently err in this direction; but even they show some improvement, their mean ratio having fallen from 14.2 per cent. in 1885 to 11.4 per cent. last year. The ratio for the whole of Scotland has steadily fallen from its hey-day in 1866, with a percentage of 10.2 to all births, and touched the lowest yet recorded in last year's 6.5 per cent. Shetland shows up best with 3.0 per cent., while the highest figure reached in the large towns is the 8.3 per cent. of Dundee, although calculated in terms of the number of possible numbers. Glasgow comes first, then Aberdeen, although it is a subject which has frequently been animadverted upon, and an intelligent investigation into the causal agents in operation, whereby rates of illegitimacy in districts close to one another should in part correspond, and in part strongly diverge under apparently similar conditions. Why does Shetland present only 3.0 per cent., and Orkney 6.1 per cent.? Elgin 12.6 per cent.; and Banff 13.4 per cent., while the contiguous county of Nairn gives 8.9 per cent., Inverness 8.4 per cent., Ross 4.3 per cent.; while Aberdeen to the south of the greater sinners shows 11.2 per cent.? Why does Peebleshire offer less than a half of the rate shown by its next door neighbour Roxburghshire? The three counties in the farthest south-west of Scotland are mainly agricultural, and so are those in the north-east; all the first three are convicted by the returns, but only some of the latter. All these counties have a sparse population from one person to 7 to 10 acres, but Ross, with only about one to every 24 acres returns an illegitimate rate of only 4.3 per cent. Among other things the number of deaths directly recorded as due to influenza in eight of the principal cities of Scotland exceeded that caused by scarlet-fever, in Edinburgh was almost double, and in Aberdeen treble the latter, and that from enteric fever. In these towns 1.15 per cent. of the total deaths were caused by it, in Aberdeen 1.80 per cent. One death from small-pox is recorded from Glasgow, and sixteen from typhus; six of these from Edinburgh, five from Dundee.

THE GLASGOW PROFESSORSHIP IN MEDICINE.—Some speculation has been aroused as to whether the unsuccessful candidates for the vacant Edinburgh Chair of Medicine will apply later for the Glasgow Professorship in Medicine which Sir William T. Gairdner has resolved to give up at the end of the Summer Session. Although Glasgow has not supplied any aspirant to the vacant Edinburgh Chair, there is little doubt of the smaller metropolis furnishing no small number of candidates for St. Mungo's professorship.

PROFESSOR JOHN CHIENE.—Although Professor Chiene ostensibly went to South Africa as chief surgeon to the Edinburgh and East of Scotland War Hospital, it appears that he will really be one of the consulting surgeons under appointment from the War Office for much wider service. In fact, he will occupy a similar post as that of Mr. Treves. Dr. Wallace will therefore be largely in charge of the hospital under Sir J. Clark, M.D.

MEDICAL SOCIETY OF LONDON.

THE meeting on Monday evening last was a clinical evening. Dr. Guthrie showed a boy, *æt.* 10, with symptoms suggestive of Thomson's disease, characterised by general tonic contraction of the muscles of the extremities on voluntary movement, with difficulty in relaxing the same. The diagnosis was questioned by Dr. Ormerod, who suggested its being Little's disease, and by Dr. Maguire, who thought it was due to a lack of higher cerebral control.

Dr. Savill showed a woman who presented skin

lesions resembling bruises, but running on to vesiculation, irregularly distributed over the trunk and limbs. The vesicles contained dark brown serum. Dr. Eddowes suggested that the case might be one of exaggerated susceptibility to bruises, while Dr. S. Taylor, in view of the fact that the patient was phthisical, though they might be tuberculous.

Mr. E. Muirhead Little showed a girl of 17, but looking like 10, who had developed knock-knee at 5, and had taken to crutches at 7. Had broken one thigh bone at five, and the other six years ago. Liver and spleen not enlarged. Lower ends of radii and ulnæ much enlarged. The bones were unusually pervious to X-rays. The quantity of calcium in the urine was less than half the normal. Mr. Kellock thought the case was probably one of mollities or fragilitas ossium, urging that rickets only affected the epiphyses and did not make the bones fragile, to which Mr. Little replied by asserting that rickets affected the growing bone as a whole and that fracture of bones was not uncommon.

Dr. H. A. Cayley showed a man suffering from abdominal aneurism, with a history of syphilis sixteen years before. Great improvement had taken place under absolute rest, restricted diet, and large doses of iodide of potassium.

Dr. Alfred Eddowes showed a case of psoriasis and osteoarthritis in the same patient, a married woman, *æt.* 31. She was well grown, but slight; married ten years, no children; no history of rheumatism or gout in family. The outbreak of psoriasis commenced 17 years ago simultaneously with the appearance of menstruation, a coincidence not uncommon. Five years ago she suffered a good deal of worry and mental strain, and four years ago the enlargement of the joints commenced. He showed photographs illustrating a similar combination of disease in a male patient, *æt.* 33. He also showed a youth suffering from simple general ichthyosis.

Dr. Kingscote referred to a case of the kind successfully treated by three weeks' continuous bath and the administration of thyroid extract.

Dr. Robert Maguire showed a case of paraplegia in a deep sea diver following an abrupt rise to the surface from a depth of 170 ft. The patient had had several previous attacks, and was gradually improving.

Mr. F. C. Wallis showed an old man who had fractured his left patella three times in 35 years. The joint was now in a condition of hydrarthrosis.

THE IRISH COLLEGE OF SURGEONS TO THE QUEEN.

THE following address has, by the unanimous vote of the President and Council of the College, been presented to Her Majesty the Queen:—

May it please your Majesty,

We, the President, Vice-President and Council of your Majesty's Royal College of Surgeons in Ireland, avail ourselves of your presence in Dublin to renew to you the assurance of our devotion and allegiance to your Majesty's throne and person.

Our College was incorporated by your Royal ancestor, King George the Third, in the year 1784, with the primary object of providing properly trained and educated Surgeons for His Majesty's Navy and Army.

Since that date, many thousands of our countrymen, as Fellows and Licentiates of this College have served as surgeons in the naval and military forces of the Empire.

At the present moment a very large proportion of the officers of the Royal Army Medical Corps serving with such distinction in South Africa, are Fellows or Licentiates of this College, and it is to us a legitimate

source of pride and satisfaction, that the valour and devotion displayed by our countrymen, serving as combatants in the ranks of your Army, have been equalled by the devotion and self sacrifice exhibited by our Fellows and Licentiates as officers of the Royal Army Medical Corps.

We humbly desire also to convey to your Majesty the expression of our gratitude for having recently granted to the officers of the Army Medical Service the status and prestige of a Royal Corps. Such action on the part of your Majesty will enable this college to co-operate with your Majesty's advisers in making the Royal Army Medical Corps even more successful in the future than it has been in the past. To assist by every means in our power in all measures intended to strengthen the naval and military forces of the Empire is the highest object of our ambition. In conclusion, we humbly pray that it may please God to spare your Majesty for many years to direct and guide the affairs of your great Empire, and to enjoy the love and devotion of all your subjects.

Obituary.

SIR DOUGLAS MACLAGAN, M.D., F.R.C.P., F.R.S.E.D.

YET another of the prominent members of the profession in Edinburgh has been removed by death; this time one full of years and the rewards of merit. Sir Andrew Douglas MacLagan, almost invariably known by the name of Douglas MacLagan was born in 1812, and thus had reached the great age of 88 at the time of his death. His father was also a medical man, Dr. David MacLagan, who was the first to be distinguished by election to the presidency of both the Royal Colleges of Physicians and of Surgeons of Edinburgh, as his son was the second and only other so honoured. Educated at the Edinburgh High School and the University of Edinburgh, he obtained the licentiate of the Royal College of Surgeons, while but nineteen years of age, a Fellow of that College, and M.D. of the University two years later. For nearly eighteen years he lectured on *Materia Medica* in the Edinburgh Extramural School, and in 1862 was appointed by the Crown to the Chair of Medical Jurisprudence on the death of Professor Traill, a post which he only resigned in 1896 on account of advancing age, having for the long period of thirty-four years filled the important duties of the Chair, and of Professor of Clinical Medicine in charge of wards in the Royal Infirmary, which then accompanied the University post, for much of that time with great ability. His career in the Royal Infirmary was somewhat exceptional, for shortly after graduation he became as assistant surgeon to the hospital, a post he resigned later, when he devoted his energies more particularly to the study of *materia medica*, while later he was placed in charge of medical wards in virtue of his academical professorship. Had Sir Douglas remained faithful to his first love, Edinburgh would have lost an illustrious toxicologist, an excellent instructor of undergraduates in medical jurisprudence, the medical students in legal matters, the legal students in medicine. During his long apprenticeship in *materia medica* he obtained an intimate acquaintance with the pharmacological actions and physical characters of poisonous drugs, a knowledge which he further developed in the conduct of his University Chair to such good purpose that for years he was regarded as the foremost authority in forensic medicine, and more especially in toxicology in Scotland; indeed, for about fifty years he advised the Crown in all criminal trials in which expert aid was necessary. He figured as a Crown witness in several famous trials—in the Pritchard poisoning case, and the trial of Chantrelle; the defence in the still better known Madeleine Smith case.

By his death another link with the past is broken, for he had personally known Sir Walter Scott, and had visited Goethe in Weimar in his youth. Possessed of a thorough knowledge of the classics, and of German, and equipped with a real touch of poetical talent, Sir

Douglas contributed during his long life many songs and poems to amuse or instruct his medical *confrères*, several of which should be long remembered. A number of his songs were published years ago in book form under the title of "*Nugæ Canoræ Medicæ*." An enthusiastic volunteer, he was appointed Surgeon-Major of the Queen's Edinburgh Volunteer Brigade in 1859; while the Royal Bodyguard of the Queen in Scotland, the Royal Company of Archers made him its Surgeon-General. He was knighted in 1886 in recognition of his services to medicine; Glasgow conferred the honorary degree of LL.D. upon him in 1891, his Alma Mater following suit in 1897. He also held the post of President of the Royal Society of Edinburgh, and was one of its vice-presidents last year. A kindly-mannered, courteous, conscientious, but withal a humorous nature, Sir Douglas MacLagan succeeded by dint of quiet perseverance in his more public life work, unassisted by any display of "push" or ambitious self-advertising; perhaps had he directed as much mental energy into his professional career as he showed in connection with many of his social attainments, he might have made a greater and more widely-known name for himself. A polished gentleman of the old school, what he had to do he did well; what lay beyond this he did not attempt. In private and semi-private life his nature seemed to change, to become that of a brilliant conversationalist and raconteur, a lively and witty companion, of one possessed of an active mind, not that displayed in the methodical, painstaking, trustworthy, but hardly brilliant disquisitions delivered to his students upon the details of his somewhat technical subject.

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

MR. MCWALTER AND HIS DIPLOMA.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

Dear Sir,—In the issue of your paper THE MEDICAL PRESS AND CIRCULAR of the 21st ulto., you state that our client Dr. J. C. McWalter was called upon to resign and did resign the Diploma of the College of Physicians. The inference to be drawn from this statement is that our client was guilty of such dishonourable conduct as justified the College in summarily calling on him to resign and this statement, which is untrue, is seriously calculated to injure our client in his personal and professional character.

In the letter of November 11th last, written by the Registrar of the College to our client, he simply called on him to sever his association with a certain firm with which he was connected, and were it possible for him to comply with this he could have continued Licentiate of the College. Our client, however, was not in a position to do this, and therefore sent in his resignation, which was accepted. Therefore his resigning was a voluntary act on his part, but the paragraph complained of in your paper by inference throws a slur on him which the circumstances do not justify.

He has placed the matter in our hands to institute proceedings for damages for libel, but as his only object is to have his character and position vindicated, we have little doubt that when matters are made clear to you, you will not hesitate to make proper amends in your paper, and if you do so our client will be satisfied.

We are, Sir, yours, truly

CROWLEY AND BOLGER.

50, Lower Sackville Street, Dublin, April 5th, 1900.

[If Mr. McWalter considers that the hypothetical damage to his professional character can be cured by our stating the exact facts, we are willing to do so as we have no desire to be unjust. The Royal College of Physicians, on November 11th, required him, within fourteen days, to furnish satisfactory evidence that he had severed all connection with the shops of Leonard and Co., and intimated that, failing the production of

such evidence, the College would proceed to deprive him of his diploma. On November 23rd, Mr. McWalter intimated that it was not convenient for him to adopt the first alternative, and he accordingly resigned his diploma. We must leave it to public judgment whether Mr. McWalter's resignation under the circumstances was "a voluntary act" or not. As he appears to be able to recognise in the transaction a distinction without a difference which is too subtle for our comprehension, we have now modified our original statement by narrating the exact facts.—[ED.]

Medical News.

The Medical Sickness and Accident Society.

The monthly meeting of the executive committee of the Medical Sickness, Annuity, and Life Assurance Society, was held on 30th ult. at 429, Strand, London, W.C. There were present Dr. de Havilland Hall in the chair, Dr. J. B. Ball, Dr. G. E. Herman, Mr. J. Brindley James, Dr. J. W. Hunt, Mr. F. S. Edwards, Dr. M. Greenwood, Mr. Fred Wallace, Dr. F. J. Allan, Dr. Alfred S. Gubb, Dr. Walter Smith, and Dr. W. Knowlsey Sibley. The committee examined and discussed the list of claims which, as is usual at this period of the year, was greatly increased by the bronchial affections to which medical men, and particularly those practising in the country are specially exposed in the spring. The influenza epidemic appears to have nearly exhausted itself, but the inclement weather of the last four weeks has compelled a considerable number of the members of the Society to lie up for a short time, and has thus produced a long list of claims. These, however, are nearly all of short duration, and the total sickness experience of the Society for the first three months of 1900 compares very favourably with the records for the early part of last year. Prospectuses and all particulars on application to Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

Gresham Lectures.

LECTURES on "Military Ambulance" will be delivered on April 24th, 25th, 26th, and 27th, 1900, at 6 p.m., by E. Symes Thompson, M.D., F.R.C.P., Gresham Professor of Medicine, at Gresham College, Basinghall Street E.C. The lectures are illustrated by diagrams, are free to the public, and commence each evening at 6 p.m.

Lead Poisoning.

THREE cases of lead poisoning have occurred in London during the three months ending March 31st.

Lithographed Signatures.

A NUMBER of summonses issued against defaulters under the vaccination law, at Ilford, were dismissed on Saturday last on the ground of informality, in that the notices served by the Vaccination Officers only bore a lithographed instead of a written signature.

PASS LISTS.

THE following candidates, having passed the necessary examinations, received their degrees on March, 30th:—

Victoria University.

Bachelor of Medicine and of Surgery.—First-class Honours: Charles John Nepean Longridge, St. George's Hospital. Second-class Honours: Albert Earnest Finney, Owens; Thomas Percy Allen and William Edward Bamber, M.Sc., Owens; William Henry Wood, University; Harry Howard Bywater, Owens; Sidney Smalbrooke, Depree, University; William Alexander Helm, Edward Falkner Hill, John Frederick Hodgson, Henry Holt, and Samuel King, Hutton, Owens; Frederick Thomas Alexander Lovgrove, University; Frederick Alexander Morrison, Owens; William Harold Morrison, Yorkshire; and Harry Scholefield, Owens.

At examinations held in March in the Faculty of Medicine the following candidates were successful:—

FINAL EXAMINATION.

Part I.: Grenville Ainsworth, Owens; E. W. Anderton, Yorkshire; M. B. Arnold, Owens; J. L. Beddoes and J. H. Billings, University; George Binns, Owens; J. W. H. Brown, Yorkshire; Fred Boulough, Owens; E. T. Forster, Yorkshire; J. P. Good, Walter Hickey and James McIlraith, Owens; A. F. Martin and Edwin Saville, Yorkshire; Harry Slater, Owens; J. H. Sudcliffe, Yorkshire; George

Taylor, Herbert Terry, Thomas Tierney, W. H. Tomlinson, J. W. Watson, and H. M. Williamson, Owens; F. P. Wilson, University; and W. J. Woollyatt, Owens.

SECOND EXAMINATION.

A.—Anatomy and Physiology.—Alexander Anderson, Yorkshire; J. W. Anderton, Owens; Roy Appleton, Yorkshire; J. B. Barnes, Owens; H. M. Berry and J. P. Bligh, University; L. B. Braithwaite, Yorkshire; Walter Briggs, G. H. Brown, and G. G. Buckler, Owens; Alexander Burkhardt, Yorkshire; A. G. Christian, E. H. Cox, A. J. Edmunds, R. B. Fletcher, A. H. Gregson, and P. T. Harding, Owens; J. L. Hawkes, University; F. W. Hayes, Yorkshire; H. E. Heapy, University; Alexander Hodgkinson, Owens; A. S. Hopper, University; Arthur Howard, J. B. Hutchinson, and A. E. Johnson, Owens; J. A. Johnson and C. O. Jones, University; J. A. Jones, Owens; G. W. N. Joseph, University; W. G. Kinton, Owens; R. E. Knowles, University; R. G. M. Ladell, Yorkshire; A. W. Litham, Owens; J. A. Longley, Yorkshire; Joseph Longworth, Owens; Harry Maffin, M. H. Potts, and A. H. Radcliffe, Yorkshire; W. E. Bothwell and F. W. Schofield, Owens; P. K. Steele, Frank Sugden, and Bertram Suggitt, Yorkshire; S. W. Swindells and A. F. Thompson, Owens; A. B. S. Todd, Yorkshire; A. E. Townley, P. E. Tylecote, David Walker, and T. B. Wolseholme, Owens; H. F. Woolfenden, University; W. S. Wrigley, Owens; and F. W. B. Young, Yorkshire.

B.—Materia Medica and Pharmacy: John Brunskill, Owens; L. T. Chadwick, Yorkshire; Alexander Cran, Robert Haslam, and E. W. Henstock, Owens; A. G. Jackson, University; C. F. Leago, H. F. Lee, J. Longworth, J. H. Nichol, G. G. Parkin, and W. B. Ramsden, Owens; J. O. Sergeant and Frank Sugden, Yorkshire; A. B. Sykes, University; A. B. S. Todd, Yorkshire; A. E. Townley, Owens; G. F. C. Walker, University; and S. A. Winstanley, Owens.

* Awarded University Scholarship.

Aberdeen University.

At the graduation ceremony on April 4th, the degree of M.D. was conferred on the following candidates:—

Frank Beaton, M.B., of Hirst, Morpeth; Hugh Gordon Cowie, M.A., M.B., of Turfiff; Arthur Burness Talbot, M.B., of Malabar, Adampur, S. Sylhet, India, Thesis—"Water Itch"; George Breibner Scott, M.B., of London; David Simpson, M.A., M.B., Major I.M.S., of Comibatore, Madras. The Thesis of Mr. A. B. Dalgetty was considered worthy of "Commendation."

The degrees of M.B. and Ch.B. under the new ordinances were conferred on the following:—

Henry Fraser, M.A., of Aberdeen, with first class honours, Henry Peterkin, M.A., of Aberdeen, Herbert Bell Tawse, of Aberdeen, and Arthur Westerman, of Aberdeen, with second class honours.

The following also received the degrees:—

William John Ironside Bruce, Dingwall; William James Caie, M.A., Aberdeen; Robert Carnegie, Peterhead; John Catto, Fintray; Arthur Robertson Kirkhill Davidson, Aberdeen; Hugh Allan Dunnydeer Davidson, Aberdeen; John Watt Duncan, M.A., Aberdeen; Sylvester Davidson Fairweather, M.A., Mintlaw, Aberdeen; George Greig Farquhar, Aberdeen; John Forbes, Fyvie, Aberdeen; John McCalman Fraser, M.A., Aberdeen; Kenneth Fraser, Inverness; William Norman Houghton, Bayswater; Wilfrid Ernest Lawson, Aberdeen; David Mitchell Macdonald, Aberdeen; John McKenzie, M.A., Dunmail, Aberdeen; Ernest Hunt Nash Holmleigh, Stafford; Wm. Douglas Pringle, Alexandria, Egypt; John Richardson, Monifieth, Forfar; James Andrew Simpson, Alford, Aberdeen; Harold Trail Skae, Kirkwall; Robert Alex Slessor, M.A., Aberdeen; Charles Lawson Smith, Aberdeen; Harry Emslie Smith, Summerhill, Aberdeen; Arthur Leslie Sutherland, M.A., Aberdeen; James Taylor, M.A., Mintlaw, Aberdeen; James Miller Swanson Wood, Torry, Aberdeen. *Passed final examination "With Distinction."

The degrees M.B. and C.M. under the old ordinances were bestowed on the following:—

Joseph Hadfield, Hadfield, near Manchester; Francis Walker Moir, Cults, Aberdeen; Douglas Whimster Keiller Moody, Montrose; William Mitchell Smith, Strichen, Aberdeen; William Peters Young, Aberdeen.

Diploma in Public Health.—James McRae Cowie, M.A., Turfiff; James Dawson, M.A., M.B., Rathen; Alfred James Hynd, M.B., Aberdeen; James Alex. Stephen, M.A., M.B., Elgin; Alexander Urquhart, M.A., M.B., Old Meldrum. "With Credit."

Society of Apothecaries of London.

Primary Examination, Part I. April 4th and 5th, 1900. The following candidates passed in:—

Biology.—E. Renouf, J. A. Renshaw. Chemistry: B. F. Board, L. V. Hill, R. L. Jones, C. Kellgren, D. Mann, J. E. Mondon, E. Renouf, J. A. Renshaw, C. A. Sampson, J. M. Worswick.

Materia Medica and Pharmacy. T. M. Burton, W. H. Cotton, A. T. Harvey, P. P. Jocelyne, J. A. Renshaw, C. M. Scott.

Primary Examination, Part II. April 2nd, 4th, and 5th, 1900. The following candidates passed in:—

Anatomy: C. E. Adams, C. M. L. Cowper, L. Denny, E. M. De Wilton, W. Garton, W. Hunter, H. Jacques, F. H. Maberly, H. J. May, F. Murray, A. R. Phelps, C. H. Pring, W. P. Taylor.

Physiology: C. E. Adams, W. H. Bush, P. S. Cooke, C. M. L. Cowper, L. Denny, A. W. Ellis, H. R. Grellet, H. Jacques, S. A. Mahmood, H. P. Margetts, S. Newmark, H. A. Parker, A. R. Phelps, C. H. Pring.

Royal College of Surgeons in Ireland.

Fellowship Examination: Mr. Thomas Joseph O'Donnell, L.R.C.S.Irel, Ooregum, Mysore State, India, having passed the necessary examination, has been admitted a Fellow of the College.

Notices to Correspondents, Short Letters, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

LOCAL REPORTS AND NEWS.—Correspondents desirous of drawing attention to these are requested kindly to mark the newspapers when sending them to the Editor.

READING CASES.—Cloth board cases, gilt lettered, containing twenty-six strings for holding the numbers of THE MEDICAL PRESS AND CIRCULAR, may now be had at the office of this journal, price 2s. 6d. These cases will be found very useful to keep each weekly number intact, clean, and flat after it has passed through the post.

ORIGINAL ARTICLES or LETTERS intended for publication should be written on one side of the paper only, and must be authenticated with the name and address of the writer, not necessarily for publication, but as evidence of identity.

REPRINTS.—Authors of papers requiring reprints in pamphlet form after they have appeared in these columns can have them, at half the usual cost, on application to the printers before the type is broken up.

MEDICAL DIAGNOSIS AD VALOREM.

The pension examining surgeons in the States have a knack of valuing sundry and various disabilities on behalf of claimants strikes one as funny. Here is one of these detailed accounts:—

dols.		dols.	
For general debility.....	30	For alleged periodical ver-	
For deafness.....	25	tigo.....	17
For disease of eyes.....	30	For rheumatism.....	17
For disease of rectum.....	30	For disease of heart.....	30
For disease of liver.....	30	For tenderness over spleen.....	17
For crepitation of shoulders			
and elbows.....	17	Total.....	243

We cannot resist the temptation to give one other sample of this medical hardware:—

dols.		dols.	
For thin, flabby muscles and		For a rectal ulcer.....	17
located tremulous tongue.....	17	For slight rheumatism.....	17
For thin abdominal walls		For slight disease of heart.....	17
and tenderness over colon		For slight gunshot wound	
and stomach.....	17	of right leg.....	12
For practically normal liver.....	12		
For four medium-sized piles.....	17	Total.....	126

PERPLEXED.—Before crediting the vaccination theory of the eruption, make sure that it is not of medicinal origin. Inquire particularly whether the mother has been taking bromides, iodides, or the balsams. We know of a case to which indeed great publicity was given at the time in which the cutaneous manifestations turned out to be due to the mother's taking a mixture containing bromide of potassium.

Dr. W. K. Your announcement is calculated to cause surprise as well as regret, but if you decide to obtain a judicial decision, the usual course is open to you.

"**NERVI.**"—(1) If Nervi is too relaxing you might try Pegli (as it is so near Gervia and Nervi) for the two or three weeks before you go to Aix-les-Bains. Dr. Wagner describes the Pegli climate as "soft and mild, yet stimulating; a mean between the damp of the Riviera di Levante and the dry heat of Montone." Professor Lobert asserts "it surpasses all others in Italy." (2) You can very safely go the first week in May to Aix-les-Bains. (3) At Milan go to the Hotel Continental.

QUESTIONS FOR MEDICAL STUDENTS.

1. DEMONSTRATE by analogy the utility of the solar plexus in comparison with the solar system? 2. Under what conditions is the kidney found "friable"? 3. In cases where blackwash had been tried and failed to have the desired effect would you feel inclined to substitute whitewash, both being mainly composed of lime-water? 4. Explain the vermicular action observed by microscope in the Wormian bones? 5. It has been recommended to place a piece of soap in a heavy sleeper's mouth to prevent snoring. Would you consider it would have too "soporific" effect? 6. Would tea be a suitable article of diet for a female diabetic patient suffering in addition with excessive mammary secretion? 7. Which do you consider most difficult to pass—a catheter or an examination?

Meetings of the Societies and Lectures.

WEDNESDAY, APRIL 11TH.

HUNTERIAN SOCIETY.—At the London Institution (Finsbury Circus), at 8.30. p.m., when cases will be shown.

Appointments.

CHALMERS, D.A., L.R.C.P., L.R.C.S.Ed., L.F.P.S.Glas., Military Surgeon at Castlehill Barracks, Aberdeen.

JOHNSTONE, JAMES PIERCE, L.R.C.P., L.R.C.S., L.M. Edin., Deputy Medical Officer of Health for Langport (Somerset).
LONGFORD, J.M., L.R.C.P., L.R.C.S.Irel., Resident Assistant Medical Officer to the Workhouse and Assistant Medical Officer to the Cottage Homes, Ashton.
LORD, S. T., L.R.C.P.Lond., M.R.C.S., Medical Officer by the District Council of Castleton.
MACKAY, H. J., M.D. Ed., Certifying Surgeon under the Factory Act for the Borough and Rural District of Devises.
McKEAGUE, JOHN, L.R.C.P. and S. Edin. (Civil Surgeon), by the War Office to the Station Hospital, Fallowfield Barracks, Preston.
MILLIGAN, W. ANSTRUTHER, M.A., M.B., C.M. Aberd., F.R.C.S. Ed., Assistant Anesthetist to the Great Northern Central Hospital, Holloway Road, London.
O'DONERTY, E. H., L.R.C.P.Irel., M.R.C.S., Acting Medical Superintendent of the Quarantine Station, Peel Island, Brisbane, Queensland.
ORR, VIVIAN B., M.B., B.S. Melb., M.R.C.S., L.R.C.P.Lond., Senior House Surgeon to the Westminster Hospital.
WATSON, A. E., L.R.C.P.Lond., M.R.C.S., Certifying Surgeon for the Borough of Torquay, the Urban Districts of Cockington and St. Mary Church, and the Civil Parish of Stoke-in-Teignhead, Newton Abbot.

Bacancies.

Bath Royal United Hospital.—Resident Medical Officer for three years. Salary £100 per annum, with board, lodging, and washing.
City of Dublin Hospital.—Resident Medical Officer. Applications to be sent to Mr. G. Jameson Johnston, Hon. Sec., Medical Board, before 21st inst.
Cumberland and Westmorland Asylum, Garlands, Carlisle.—Junior Assistant Medical Officer, unmarried. Salary £100 a year, with board and residence.
Liverpool.—Assistant Medical Officer for the Workhouse, Brownlow Hill. Salary £80 per annum, with ration. An additional sum of £20 being allowed for examining applicants for out-door relief. Subject to superannuation deductions. Apply to the Vestry Clerk Parish Offices, Brownlow Hill, Liverpool.
Killminster Infirmary and Children's Hospital.—House Surgeon, unmarried. Salary £140, increasing annually by £10 to £170, with rooms in the Infirmary and attendance. Option of board at £40 per annum.
North Riding County Asylum, Clifton, York.—Senior Assistant Medical Officer, unmarried. Salary £150, rising to £200, with board, apartments, washing, and attendance.
Parish Council of Uig, Island of Lewis.—Medical Officer and Public Vaccinator. Salary £200, exclusive of certain fees. Applications to the Chairman of the Parish Council.
Parish of St. Giles, Camberwell, London.—Assistant Medical Officer for the Workhouse, at Gordon Road, Peckham. Salary £120 per annum with furnished apartments outside the workhouse, and an allowance of £1 ls. weekly in lieu of board and washing. Apply to the Clerk, 21, Peckham Road, S.E.
Peckham House Asylum, Peckham, S.E.—Junior Assistant Medical Officer. Salary £130 per annum, with board and lodging.
St. Saviour's Union, Surrey. Second Assistant Medical Officer at the Infirmary, East Dulwich. Salary at the rate of £200 per annum with residential allowances. Apply to the Clerk, Offices, John Street West, Blackfriars Road, S.E.
Sunderland Infirmary.—House Surgeon. Salary £80, rising £10 annually to £100, with board and residence.
West Ham Lunatic Asylum.—Superintendent. Asylum now in course of erection at Chadwell Heath, Essex. Salary £600 per annum, with unfurnished house, light, washing, and garden produce. Apply to the Town Clerk, Town Hall, West Ham, E.
West Riding Asylum, Wakefield.—Assistant Medical Officer as Locum Tenens. Salary £3 3s. per week, with apartments and board.
Weston-super-Mare Hospital.—House Surgeon, unmarried. Salary £100 per annum, with board and residence in the hospital.

Births.

SALISBURY-SHARPE.—On April 7th, at 8, Cleveland Terrace, Hyde Park, London, the wife of W. Salisbury-sharpe, M.R.C.S., L.R.C.P., of a daughter.

Marriages.

BELL-ROSS.—On April 3rd, at St. Mary Abbott's, Kensington, Robert Bell, M.D., F.F.P.S. &c., of Glasgow, to Clara Ellen, widow of Hugh Ross, of St. Helens Bay, Co. Down.
BUTLER-REED.—On March 20th, in the Cathedral, Cap-town, by the Dean, Thomas Harrison Butler, B.A., M.B., B.Ch., Oxon, M.R.C.S. Eng., L.R.C.P., of Port Elizabeth, Cape Colony, eldest son of Rev. G. W. Butler, Rector of Broad Mayne, Dorchester, to Ellen, second daughter of W. H. Reed, M.R.C.S., L.S.A., of Allersleigh, Westbury, Wiltshire.

Deaths.

CAMERON.—On April 2nd, at Great Portland Street, W., George Fenton Cameron, M.D., J.P., aged 75 years.
MACLAGAN.—On April 5th, at his residence, 23, Heriot Row, Edinburgh, Sir Douglas MacLagan, M.D., LL.D., F.R.S.E., aged 88 years.
SMITH.—On March 5th, at Waverley, Sydney, Australia. F. Moore Smith, M.D., late of Much Hadham, Herts, aged 71.

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No. 16.

Three Lectures ON THE SURGERY OF THE STOMACH. (a)

By A. MAYO ROBSON, F.R.C.S.ENG.,

Member of the Council and Hunterian Professor of the Royal College of Surgeons of England; Emeritus Professor of Surgery in the Yorkshire College; and Senior Surgeon to the Leeds General Infirmary.

ABSTRACT OF LECTURE III. (b) INJURY OF THE STOMACH.

THE stomach is seldom ruptured from blunt force applied to the abdominal wall, though contusions and partial or complete rupture may occur from a blow or kick in the epigastric region when the stomach is full. The vomiting of blood, therefore, with pain over the stomach immediately following a blow, may demand exploration. It would be wise, however, before resorting to operation to inflate the stomach, as if a rupture has taken place, gas will escape into the peritoneal cavity and the liver dulness will disappear, whereas if the organ be unruptured, the distended stomach will be clearly outlined through the abdominal wall. In case of doubt, a small incision in the middle line above the umbilicus will speedily settle the question, for if the stomach is ruptured there will be an escape of odourless gas immediately the peritoneum is opened, and in all probability bloodstained fluid from the stomach contents would also escape. Needless to say, in case of rupture, no time should be lost in first arresting hæmorrhage, and then closing the laceration and cleansing the peritoneum.

Gunshot and stab wounds of the stomach are not infrequent, and there are now numbers of cases on record where the stomach has been perforated by a bullet and recovery has occurred. In stitching up the stomach, Lembert's sutures must be applied well beyond the wound at both extremities.

The older authors relate numerous cases of successful treatment of wounds of the stomach, but in many a fistula was left. Nearly all cases of spontaneous rupture of the stomach are due to ulcer or carcinoma, but we should not forget that there are a number of cases on record in which rupture has occurred from over-distension. Recovery probably never occurs naturally in these spontaneous ruptures, but there are many cases on record of recovery after stab wounds. Perforation may occur from within, as in the case of sword and knife swallows.

CANCER AND OTHER TUMOURS OF THE STOMACH.

Cancer of the stomach, which is more common in men than in women, in the proportion of two to one, may occur at any period of life from youth to extreme old age, but it is most commonly found between fifty and sixty, and may be said to be a disease of middle or advanced age. Sarcoma occurs less frequently,

and usually at earlier periods. Tubercle of the stomach is uncommon, except in children affected with general tuberculosis. I have only operated in one case in a girl of 12, who, besides the pyloric stenosis due to tuberculous disease, had stricture of the duodenum, general tuberculous disease of the stomach, and tuberculous peritonitis. Fibromyoma of the stomach is rare, but it may form a pedunculated growth projecting as a polypus into the stomach, and if it be away from the pyloric extremity it may produce no symptom until its size demands attention. Polypoid outgrowths of the mucous membrane, which may be termed adenoma or papilloma, are uncommon, but in one case that came under my care a polypus of this nature was obstructing the pylorus, the obstruction being successfully relieved by its removal. The stomach may also be the seat of lipoma, lymphadenoma, villous growth, and, secondly, malignant tumours.

Fibroid thickening of the pylorus may form a tumour which can with difficulty be distinguished from malignant growth, and on two occasions I have performed pylorotomy in such cases under the impression that I was removing a cancer; such a tumour is dependent on the deposit of lymph around a pyloric ulcer, which, becoming changed into fibrous tissue, not only causes great thickening of the pylorus, but leads to matting of the omentum around it, and to puckering and hardening of the tissues that in some cases can only be distinguished from cancer on section or on microscopic examination. The long-continued history of ulcer may be the only guide to the diagnosis, but in this connection it must be borne in mind that a chronic ulcer may end in cancer.

Diagnosis.—When the symptoms and signs of ulcer of the stomach with or without stricture, but with tumour, are found at or after middle age, the probability is that the patient is suffering from cancer.

Cancer of the cardiac extremity can seldom be felt until it has attained a considerable size, and cancer of the pylorus often cannot be distinctly felt until it has formed a fairly large tumour; though in most cases an indefinite sense of fulness and hardness leads to a suspicion of growth before it can be distinctly defined. The tumour usually moves up and down by respiration, and when the pylorus is free from adhesions it may be felt quite easily well away from the costal margin.

While in cancer of the cardiac orifice the stomach is usually contracted and small, in pyloric cancer it becomes dilated, and the dilatation may be the prominent sign. Inflation will not only render it possible to estimate the size of the organ, but to distinguish between a retroperitoneal and a pyloric or stomach tumour, and to ascertain the relation of the tumour to the stomach cavity. In cancer of the head of the pancreas jaundice and a distended gall-bladder are usually present, and inflation will show the relation of the stomach to the tumour.

(a) Delivered in the Theatre of the Royal College of Surgeons of England, March, 1900.

(b) Lecture I. was published in THE MEDICAL PRESS AND CIRCULAR of April 4th, 1900.

Bleeding in cancer of the stomach is usually shown as grumous vomit, seldom as a large hæmatemesis, as in ulcer; and melæna is rare. The pain is more constant than in ulcer, and not so distinctly after food. It may be absent, but in one form or another is present in 90 per cent. of the cases, and is usually very severe.

On examining the stomach contents after a test meal, the absence of free hydrochloric acid is very suggestive of cancer as is the presence of free lactic acid, but the presence of free hydrochloric acid does not negative the existence of cancer. Loss of flesh occurs from the outset, and cachexia supervenes at an earlier stage than in cancer elsewhere.

It would almost seem incredible that cancer of the stomach may exist in a latent form and produce death by exhaustion without any of the characteristic symptoms, but I have seen a case of this kind in a man of 70, and others have reported similar cases.

Before a tumour is felt, there may often be a difficulty in diagnosing between pernicious anæmia, tubercle and cancer of the stomach, but when persistent indigestion comes on after 50 for the first time, it is very frequently due to cancer. At times carcinoma can only be diagnosed by the resistance present when the patient is deeply anæsthetised.

Prognosis.—As surgery holds out the only hope of relief or cure, and as, moreover, the earlier these cases are seen by the surgeon the greater is the probability of real good being done, it would seem to me that in every case where cancer of the stomach is suspected, the question of surgical treatment should be considered at a much earlier period than is now the custom. It is important to note that out of 38 cases of cancer of the stomach collected by Drs. Parry and Shaw, in 18 per cent. there were no secondary deposits in other organs, and that Gussenbauer and Winikwater, as a result of the examination of the register of 542 cases of cancer of the pylorus, state that in 41 per cent. there was no metastasis, and that in 37 per cent. there were no adhesions. One may reasonably hope therefore to perform a radical operation in one out of three or four cases of cancer of the stomach, if surgical means be adopted sufficiently early. Cancer of the stomach *qua* cancer is more favourable for radical treatment than cancer of the breast or the tongue; and now that the technique of the radical operation is becoming more perfect, I venture to predict that we shall in the future give our patients the chance of the aid of relief by operation more frequently, and that surgery will be sought as soon as the disease is recognised. Every life saved is a life gained, so that if we can only save 50 per cent. by the radical operation it is well worth doing, since patients with cancers of the stomach can only at the best have a miserable and hopeless existence unless treated surgically.

The prognosis is at present much more favourable than it was in the past. In order to still further lower the mortality it will be necessary that patients be placed in the hands of the surgeon earlier than has hitherto been the case.

Surgical Treatment.—The treatment of cancer of the stomach may be radical or palliative. The first procedure will in all cases thought suitable for operation consist of an exploratory abdominal section, and according to the condition found will depend the after treatment. In Czerny's clinic there were 24 exploratory operations for cancer, with a mortality of 25 per cent., and the duration of life after operation was usually less than five months. I have myself performed eight exploratory operations for cancer of the stomach, and, finding enlarged glands or secondary deposits, have at once closed the abdomen. All the cases recovered from the operation, and lived for various periods.

Preparation.—The bowels should be cleared either

by an aperient or enema the night before operation, and the stomach should be washed out an hour or two before if the patient be in a condition to bear it. As these patients bear shock badly it should if possible be prevented. The operating room should have a temperature of 70° F., and the patient should be enveloped in cotton wool, which may be conveniently carried out by a long-sleeved jacket and long stockings made of gamgee tissue. An artificially-heated operating table is an advantage, and if a specially-heated table be not at hand, an oblong water cushion filled with hot water, or a series of indiarubber water bottles placed under the blanket of the operating table will take its place. An injection of liq. strychninæ $\mathcal{M}$ x, given before the administration of the anæsthetic, supplemented by another injection if necessary during the operation, is useful. An infusion of saline solution may be required; the apparatus for transfusion should therefore always be ready, as it can be used by a colleague while the operation is proceeding, or the saline fluid may be steadily injected in good quantities into the subcutaneous tissue of the axilla, either by means of a large syringe or by an ordinary aspirator needle connected with an india-rubber tube and glass funnel, which can be easily arranged by a nurse and used continuously for a little time. After operation the patient should be placed in a warm bed and surrounded by hot-water bottles, and I always order a pint of warm saline fluid with an ounce of brandy, to be injected into the rectum immediately after the operation, the injection to be repeated if the pulse seems to indicate its necessity.

PYLORECTOMY.

Pylorectomy is the removal of the pylorus and as much of the adjoining part of the stomach and duodenum as may be involved. The operation has been much modified since it was first performed by Péan in 1879 and Billroth in 1881, it being then done by suturing the open end of the duodenum, after removing the disease, to the open end of the stomach, and closing by sutures the remainder of the stomach opening not fixed to the bowel. In one operation of this kind that I reported before the Royal Medical and Chirurgical Society in 1891, contraction by the newly-made orifice ensued some months later, and in order to avoid a like accident I modified the operation by employing a bone bobbin, around which to join the open ends of the stomach and duodenum by sutures, thus securing adequate patency of the new channel. As time is a very important factor in any operation on the stomach, the rapid procedure of making the junction by means of a Murphy's button has found favour with many operators, though Professor Kocher speaks against its use.

A further modification, now frequently followed, is to close completely both the stomach and duodenal openings, either by a purse-string suture or by a double row of stitches, and then to connect the bowel to the stomach, making either a gastro-duodenostomy or a gastro-jejunoostomy, whichever may be thought most easy and expeditious at the time. This will depend very much on the amount of stomach that has to be removed in order to get away the whole of the disease, for if much stomach has to be removed, the open end of the duodenum will be less easy to fix to the stomach than a free loop of the jejunum. This operation is the one favoured by Professor Kocher, and in his hands it has proved very successful. He uses strong forceps in closing the lumen of the stomach and bowel, instead of employing digital compression and as a suture he uses silk exclusively. Doyen's method of *écrasement* is very expeditious.

The performance of the operation *en deux temps* was suggested by Tupolske in 1891. He first performed a gastro-enterostomy, and then, when the

patient had recovered, he removed the pylorus three months later, closing the openings in the stomach and bowel, and leaving the gastro-enterostomy opening to continue the communication with the intestine. This method, which has been followed by Quénu, Czerny, Hahn, Franke, Kummel, Barker, and Doyen, may certainly be advantageous in some cases where the patient is much exhausted and unfit to bear the longer operation of pylorotomy, as after the gastro-enterostomy strength will be gained, and later the larger operation may be borne. The gastro-enterostomy may, however, give so much relief that the patient cannot always be brought to see the necessity of the second operation until it is too late to perform a successful operation; this has been my experience in one case.

I have prepared a table of cases of pylorotomy, or partial gastrectomy, with the help of Mr. Willmott Evans, containing 572 cases, with 174 deaths, a mortality of 30.4 per cent., was shown. Haberkant's statistics show that, where adhesions were extensive, the mortality was 72.7 per cent., whereas where there were no adhesions it was only 27.2 per cent.

If the cardiac end of the stomach be involved the question of resection will be considered, and if decided on, it may be carried out in the manner described by Levy. It presents two special difficulties: (1) Danger to both pneumogastric nerves; (2) the difficulty of isolating the cardiac end of the œsophagus and fixing it to the stomach that is left.

GASTROSTOMY.

If the disease has advanced so as to produce stenosis, it will be beyond successful removal, and gastrostomy should be performed, as in stricture of the œsophagus, in order to prevent the patient dying of starvation. The operation, however, has been, and is even yet I fear with many physicians looked on as a very formidable procedure. Death by starvation under such circumstances is, however, one of the most terrible experiences both to the patient and his friends.

Why has the operation of gastrostomy acquired this ill-repute? In the first place, because it was, and even yet is as a rule, customary to defer it until the sufferer is so reduced by starvation and so enfeebled as to be unable to withstand the shock of any operative procedure. Even if he does not die of shock, his healing powers are so impaired as to lead to failure in union and then to death from wound complications, or his assimilative powers are so impoverished that, even if the operation be immediately successful, death ensues from exhaustion.

In the second place, where a direct opening is made into the stomach, the fistula in many cases speedily enlarges and becomes patulous, leading to leakage of food and of irritating gastric secretion, so that the skin of the abdomen tends to become excoriated, and the prolongation of life is attended with considerable discomfort. Do these conditions still apply? I think I shall be able to show that if the operation be performed sufficiently early, and if it be done according to the best methods, it will be found that gastrostomy may be included among the most useful and beneficent of the palliative operations the surgeon is called upon to perform. When abdominal section was attended with a high rate of mortality, it was only natural that delay should occur in advising operation; but if it can be shown that early operation has no mortality or only a slight one, due to accidental or unforeseen complications, it will be justifiable to perform gastrostomy early, knowing that the small opening will close voluntarily if the cause of the dysphagia should disappear or be cured by treatment.

The operation I am accustomed to perform is very simple, and only occupies a few minutes; it is a modification of the Ssabanjewski-Franks method, but it differs in several details. I have performed this operation in patients from 1 to

86 years of age, and with most satisfactory results. Little or no shock is experienced, as although the peritoneum is opened there is neither exposure of viscera nor handling of any organ except the portion of stomach to be fixed, and I have never known peritonitis to follow.

Where the operation is not deferred until "too late," death should not occur except from some accidental complication; for instance, I lost a patient at the end of the first week after operation from the unusual occurrence of an abscess caused by suppurating cancerous glands bursting into the trachea and flooding the bronchial tubes with pus. Even after gastrostomy for malignant stricture of the œsophagus I have known as much as a stone and a-half to be gained in weight.

Solid food may first be subjected to thorough mastication and insalivation, and then transferred by the patient from his mouth to a small funnel connected with the distal end of the catheter, where it is made to enter the stomach by blowing it through the tube, or it may be aspirated into the stomach by the patient's sudden respiratory efforts. Mastication of food, as a preliminary step to its introduction into the stomach, satisfies, at least in part, the sense of hunger, which is not always accomplished even by liberal exclusive gastric feeding through the fistula.

A comparison of the results of gastrostomy show a mortality varying between 0 and 100 per cent., so that it is impossible to state exactly the death-rate of the operation, for practically all the earlier cases died, and nearly all the later cases when performed sufficiently early recovered.

I do not think it would be an exaggeration to say that if cases of incurable stricture of the œsophagus or of obstructive cancer of the cardiac end of the stomach were handed over to the surgeon at a sufficiently early stage the mortality would not exceed 5 to 10 per cent.

If the pylorus be extensively involved there will be dilatation of the stomach, and if the patient be not in a fit condition to bear its removal, or if there be involvement of glands or secondary deposits, a palliative operation only can be performed.

JEJUNOSTOMY.

Should the disease be so extensive as not to permit gastroenterostomy, the operation of jejunostomy may be considered. I have performed it twice, but as the operation at best can only prolong life for a very short time, it is a procedure that cannot be strongly advocated.

GASTRO-ENTEROSTOMY.

For giving relief in obstruction due to cancer of the pylorus that cannot be removed, as also in many cases of simple stricture, some surgeons advocate gastro-enterostomy to the exclusion of all other operations; but it must not be forgotten that gastro-enterostomy is merely palliative, and therefore cannot be considered on the same level with operations that may prove curative by the complete removal of the disease.

The mortality of gastro-enterostomy is much greater in cancer than in simple ulcer.

TOTAL GASTRECTOMY.

If the greater part of the stomach be invaded by growth, and a careful examination of the adjoining parts reveals no secondary growths in glands or adjoining organs, complete or almost complete gastrectomy may be performed. A list, compiled by Mr. Willmott Evans, representing all the published cases of complete gastrectomy up to the end of 1899; comprises eight cases, with four recoveries, a mortality of 50 per cent.

PARTIAL GASTRECTOMY.

If the growth be limited to the body of the stomach,

partial gastrectomy may be done by a free circular or elliptical incision, the opening being closed by a continuous chromicised gut suture to the mucous margin and interrupted Lembert sutures to the peritoneal coat, all bleeding points being previously caught up and ligatured.

It seems advisable in these cases to close the gastric openings, and establish a gastro-enterostomy with the remaining portion of the stomach, but the technique will depend on the amount of stomach removed and the state of the parts left.

I am proud to be able to say that my last thirty-two operations on the stomach in my private practice have all recovered, and I can see no reason why the success in this branch of surgery should not be as great as in gall-bladder surgery, which now holds a very different position to what it did when I gave my first paper on the subject before the Clinical Society in 1885, nay even to what it did when I lectured from this chair on "Diseases of the Gall-Bladder and Bile Ducts," in 1897. In order, however, that surgery may attain its maximum amount of success, we must ask our medical colleagues for earlier diagnoses and earlier surgical consultations, so that if the case is one that can be only cured or relieved by an operation, it may be performed before the recuperative powers have been lost. Then and only then, shall we attain the ideal.

CASE OF PERSISTENT JAUNDICE, IN WHICH AN EXPLORATORY OPERATION WAS PERFORMED.

By E. F. ELIOT, F.R.C.S.ED.,
Southampton.

In January, 1900, I was asked to see Mr. S., a tall, well-nourished man, æt. 47, who was deeply jaundiced. He told me he had been jaundiced for four-and-a-half years. The jaundice had come on somewhat suddenly four-and-a-half years previously; he thought after catching a cold. There was no pain at the onset, and he had never had any pain. He told me he was passing absolutely white motions, and his urine was the colour of porter. He was anxious as to his condition, and also as to whether anything could be done to relieve him. There was nothing to be learnt from his family history. He had never had any other illness, and had never had an injury. On examination his abdomen was markedly prominent, and he was much distended. There appeared to be no free fluid of any consequence in the abdomen. There was no œdema. There was an ill-defined lump in the region of the gall-bladder, but no irregularity of the free edge of his liver could be felt. The opinion I gave was that the trouble was probably in his gall-bladder, and that I did not think there was any malignant disease. He told me he had been under medical treatment for some years, from which he had derived no benefit, and that no operation had ever been suggested to him. I told him the only thing I could suggest was an exploratory operation, and to deal with any condition which might present itself. On January 31st he saw Mr. Henry Morris in consultation, who, after weighing all the pros and cons of the case, wrote to him on February 2nd, saying, "I think an exploratory operation is the best thing for Mr. S." After hearing this opinion the patient decided to submit to an operation. On February 18th, in conjunction with my friend, Mr. C. L. Sansom, F.R.C.S. (to whom I am much indebted for his kind assistance at the time of operation, and also for seeing the patient, with me, each day afterward) I operated on the patient. When he was anæsthe-

tised the lump was carefully examined. The edge of the liver was uniformly smooth, and extended a good finger's breadth below the costal margin. A curved incision was made just below the lower border of the lump, the bleeding points were twisted, and the peritoneal cavity easily opened, when some ascitic fluid escaped (only two or three ounces). The omentum immediately bulged into the wound and some small gut. The patient had a peculiar abdominal type of respiration, and had to be more thoroughly anæsthetised. On passing my finger into the wound (after keeping omentum and gut back with a flat sponge) the gall-bladder was felt much enlarged (the size of a large French pear), and very tense and enormously thickened, and of a bright scarlet colour. I tapped the gall-bladder with a trocar and cannula, and gently emptied it, and about a pint-and-a-half of very thick black gelatinous bile came through the tube. I then enlarged the opening with Sinies forceps, and passed my finger into the bladder, when a lot more bile escaped (the orifice being packed round with sponges and iodoform gauze). At the orifice of the cystic duct there was a considerable mass of grit clinging to the mucous membrane, and bits of grit were to be felt all over the mucous lining of the bladder. This was all scraped out, and the bladder was freely washed out. The probe was passed down the duct. Nothing else abnormal was to be felt. The bladder was stuffed with iodoform gauze, and the wound sewn up in two layers. The orifice into the gall-bladder was stitched to the parietes with eight fine silk sutures. I noticed on the upper surface of the gall-bladder there was a deposit of some recent lymph; this surface was becoming adherent to the liver. I left the bladder stuffed with iodoform gauze. The cystic duct was much thickened. On coming round the patient was sick and brought up some green bile. The patient bore the operation very well; his pulse never flagged. The operation lasted exactly two hours.

February 18th.—Calomel, gr. ii., at night. Nothing by mouth.—6 p.m. Very comfortable. Temperature 99° F. Dressings changed.

19th.—Very good night. Free discharge of orange bile. Wound dressed twice, night and morning, and tube re-applied. Gall-bladder gently washed out with boracic acid. Calomel, gr. ii., night and morning. Temperature all day between 98.6° F. and 99° F. No pain. No more distension than before operation, when the abdomen was prominent and distended with flatus. Patient very bright and cheerful. Urine drawn off, twice in day, normal quantity and porter colour.

20th.—Same as yesterday in every detail. Small quantities of milk and water given.

21st.—Same as yesterday in every detail. Passed urine naturally, much the same colour. Bowels open once at 7 a.m. (hard and white). Bowels open once at 7 p.m., after enema.

22nd.—Same as yesterday in every detail. Beef tea and broth ordered. Bowels open twice (slimy and white.)

23rd.—Same as yesterday in every detail. Had a dose of Kutnow's Carlsbad salts. Three actions, colour much the same. Colour of urine distinctly lighter. Temperature in evening was 99.2° F.

24th.—Same as yesterday in every detail. Rather distended. An action after Carlsbad salts. Temperature all day normal. Medicine No. ii. ordered.

25th.—Wound very healthy. Bile coming from wound lighter in colour and not so profuse. Four actions after Carlsbad Salts. Urine lighter. Patient doing very well.

26th.—Had a good night. Everything in the morning doing well. In evening temperature went up to 101.1° F. Enema given. Result at first hard and then relaxed. No undue distension.

27th.—Temperature dropped to 98·8° F. Rose during day to 99·8° F., and 100·1° F. in evening. No. iii. and No. iv. *Mist. sennæ* co. ordered.

28th.—Has had two loose motions distinctly bile stained. Temperature 101° F. in morning dropping to 100·6° F. in evening. *Mist. sennæ* co. repeated.

March 1st.—Very fair night. Wound looking well. Sutures removed. A good deal of distension. No pain on pressure. Tongue rather dry. Ordered some champagne. Temp. 101·4° F. in morning, and 99·8° F. in evening. Decidedly not so well in evening. Two actions during the day—both bile-stained.

2nd.—Patient not doing well. Nothing wrong with wound or in region around wound. Temperature dropped to 98·8° F., and rose to 99·1° F. in evening. Tube left out and a loose strip of iodoform gauze applied to gall-bladder. Two actions during the day, markedly bile-stained. Mouth very dry, and a good deal of bleeding from gums and lips. Had some sickness and was ordered No. vi., which did not relieve him. Not sick after 9 p.m. The champagne did not suit him. Whiskey substituted for brandy. Up to now his diet was broth, beef tea, milk, barley water, Brand's essence, brandy, tea, and a little fish minced up on two occasions. At twelve o'clock at night he was slightly delirious. The distension was increasing. Hot stupes and rubbing were ordered. Had two motions during the day, both containing bile. Urine distinctly lighter in colour.

3rd.—A restless night. Not quite so distended. Good deal of bleeding from lips. No. ix. ordered, and No. viii. substituted for No. v. Temperature kept about normal. Two bile-stained motions. Sutures round orifice of gall-bladder removed, and nothing applied to gall-bladder. Wound quite healthy. Became more distended during day. Stimulants pushed, and Brand's essence and Valentine's meat juice. Seemed very drowsy at times. Quite sensible.

4th.—Not nearly so well—a bad night. Patient seemed collapsed. Pulse *very good*. Temperature, subnormal. Great distension. Two actions of bowels after *Mist. Sennæ* Co. No. x. ordered. Passed his water. No. xi. ordered. Hot stupes. Complained of no pain. Mouth in a dreadful condition.

5th.—Gradually getting worse. Distension more marked. Temperature, subnormal. Becoming more comatose. At 5 p.m. very bad. Strychnine injected and No. xii. ordered. Tube passed up rectum; large quantities of flatus passed. Urine and motion passed involuntarily. 9 p.m.—Strychnine and ether injected, Patient gradually became worse and died at 2 a.m. on Tuesday, March 6th. Nothing in or around wound to account for his symptoms.

As he had had so much bleeding from the lips and gums, it was thought he might have had some intraperitoneal oozing. The pulse was good and firm to within a few hours of his death.

Post-Mortem Examination.

Abdomen not nearly so distended as at time of death. On opening the abdomen the small gut was seen to be enormously distended and very congested. Stomach distended with flatus. Big gut not distended to any marked degree. The congestion was in patches, and was most marked in ilium. The peritoneum was quite healthy. There was a little blood-stained fluid (two ounces) in pelvis.

The region of the gall-bladder was carefully examined. The cystic and common ducts were quite patent. The incision in the gall-bladder was firmly united to the edge of wound, and there was no leaking. The gall-bladder was thickened, but interior, had a much more healthy appearance than at time of operation. There was nothing to note about the liver. The wound had healed quite firmly. It was obvious that there was nothing wrong at the seat of

operation, and that there was no lesion of the liver; that the condition had been relieved, as the duct was patent, and bile was in the intestines. The pancreas was healthy and the duct patent. The kidneys were healthy, the spleen was enlarged.

It was evident that it was a condition of acute enteritis which had caused death, and the question was what caused the enteritis. Two sections were removed for further examination. I would suggest that the tissues of the intestines had been so altered by the long continued absence of bile that the somewhat thickened, and perhaps "gritty" bile finding its way into the gut, caused an inflammatory condition to supervene.

On February 28th he passed the first bile-stained motion, and he became more distended each following day. The post-mortem shows (1) that the diagnosis was correct, and that the operation was, as far as the operation itself was concerned, successful; (2) that there was no further lesion to prevent a recovery; and (3) that it is fair to suggest that had the relief been given to the gall-bladder sooner a successful ultimate result would most probably have been attained.

I shall be very interested to hear the experience of other surgeons who have had cases with a similar complication.

- ii. Sodæ sulph., ʒj;
Tt. euonymi, ℥x;
Tt. belladonna, ℥x;
Tt. nucis vom., ℥iv;
Tt. chlorf. co., ℥x;
Tt. card. co., ʒss;
Aq. ad ʒss.

Ter die.

- iii. Sodæ sulph. gr x;
Menth pip ʒj.

Ter die.

- v. Guaiacol carb. gr. v.
Ft. lychet j. 4th hour.
viii. Acid carbolic, ℥j;
Mica Panis, gr.

4th hour.

- x. Morph. hyd., gr. ʒ;
Strychnine, gr. ʒʒ;
Quinine hydr. brom., gr. j;
Ext. gent., q.s.

One pill every 4 hours,

- xi. Mist. vini. gallici, ʒss.

Every 3 hours.

- xii. Sp. etheris sulph. co., ℥xv;
Ess. musk, ℥x;
Aq., ʒj.

Every 4 hours.

MYOTONIA CONGENITA (THOMSON'S DISEASE ?) (a)

By DR. LEONARD GUTHRIE.

THIS boy, æt. 10½, has for 12 months presented symptoms of this disease. No family history bearing on the case had, however, been elicited.

The patient, an intelligent child, was brought to hospital on account of awkwardness in using his hands and "turning in of his thumbs." A peculiar condition of tonic spasm of the hands, somewhat resembling that of tetany, was then noticed. The metacarpal bones of both thumbs were strongly adducted towards the palms, the first joint of the thumbs flexed and the second joint extended. The other phalanges were slightly flexed and the metacarpophalangeal joints extended at the first joint and the terminal phalanges were again slightly flexed. The fingers were usually widely separated from each

(a) Case shown at the Medical Society of London, April 9th, 1900

other. The wrists were flexed and inclined to the ulnar or radial side, and the elbows semi-flexed.

When asked to grasp the examiner's hand he did so with apparent effort and could not let go quickly, either slowly unfolding his finger-joints beginning with the metacarpo-phalangeal, or else drawing his hand away over the fingers he had grasped without unclasping his own.

Sometimes he could not take hold of an object without first pulling his adducted thumb outwards with the fingers of his other hand. For this reason he had difficulty in feeding himself at times.

He could execute all movements of flexion, extension and rotation of the upper extremities, but in every case the muscles employed were slowly relaxed, and a transient sense of spastic rigidity at the joints and hardness of the muscles themselves was noticeable by the observer. This condition of tonic spasm varied greatly. It was always more marked after rest and lessened after exercise, and when his attention was distracted from himself. Similar transient spasticity increased by rest and lessened by exercise, affected the lower extremities. His gait, when starting to walk, was jerky, and he did not bring his heels fully to the ground. He had difficulty in getting upstairs, always using the hand-rail to help him. He seemed to run much more easily and naturally than he could walk. He complained that his legs and arms "felt stiff," but he had no pain. A curious but undoubted fact was that the tonic contraction of muscles persisted during sleep. The boy was rather thin, but all his muscles were fairly developed. Sensation and reflexes were normal. The electrical reactions seemed natural.

Medico-Chirurgical Items.

By GEORGE FOY, M.D., F.R.C.S.

TRANSVERSE SUPRA-PUBIC LITHOTOMY.

SEÑOR DOLLET (*Arch. de Gin. y Obst.*) reports a case of stone in a boy, *æt.* 10. At six years of age the boy's parents noticed that the child had pain in passing water and all the usual symptoms of a calculus. From time to time they deferred taking the lad to a doctor until his sufferings became intense. On November 7th, 1899, he was admitted to the Jesus Ward of the Hospital for Poor Children, in Barcelona.

Dr. Recasens performed the operation. He commenced by reaching out the bladder with a solution of boric acid until the fluid returned clear. The primary incision was made in the linea alba cutting down so low on the pubes as to nick the transverse supra-pubic ligament; the bladder was found to be covered with peritoneum on its anterior surface to such an extent as to necessitate its being stripped off a portion of the viscus by the fingers of the operator. A considerable amount of yellow adipose tissue was found in the space between the posterior surface of the abdominal parietes and the anterior surface of the bladder; this tissue was undisturbed, and the bladder was drawn forward with a pair of Péan's forceps and cut transversely, immediately above and parallel to the upper margin of the pubes. The calculus, which was one inch and a half in length and an inch in depth, was withdrawn by the fingers. Two sets of sutures were introduced one for the mucous coat and one for the fibrous. Dr. Morera's analysis gives the weight of the calculus as 13.2 grammes, and its composition as uric acid with a nucleus of urate of sodium, strata of urate of ammonium and a capsule of oxalate of lime. The muscular coat of the bladder was markedly hypertrophied.

Senor Recasens, who has now performed lithotomy thirty times on children in Barcelona, concludes from his experience that the disease is principally due to the almost exclusively vegetable diet of the poor in Barcelona. In operating by the supra-pubic method, Senor Recasens has wholly discontinued the use of

Peterson's rectal bag, which he thinks is unnecessary for adults, and dangerous in the case of children.

TUBERCULOSIS OF THE BLADDER.

In a paper read before the Royal Academy of Medicine of Barcelona (*Arch. de Gin. Obst.*) Dr. Gari claims that Ambrose Paré is entitled to the honour of first pointing out the presence of tuberculosis of the urinary bladder. He gives the following quotation from Paré's seventeenth book:—"We have met with a case of a hard-walled bladder which was full of pustules, about the size of small peas, which, when squeezed, gave out a whitish pus, which also appeared to be expelled during the patient's life in his urine."

WHOOPIING-COUGH.

The following prescription of Nauwelaer's *Arch. Gin. Obst.* is recommended in teaspoonful doses for children suffering from whooping-cough:—

R Bromoform	...	...	20 drops;
Alcohol	...	...	10 grammes;
Mucilage of Tragacanth	...	...	60 grammes;
Syrup of Tolu	...	...	60 grammes.

Mix.

Professor Grassi, Montpellier, prefers the following formula:—

R Bromoform	...	...	45 minims;
Sweet Oil of Almonds	...	...	15 grammes;
Gum Arabic	...	...	10 grammes;
Syrup of Oranges, or of Mint	...	...	30 grammes;
Water	...	...	60 grammes.

Mix.

Senor Marfan has for a long time past has used the following prescription:—

R Bromoform	...	...	48 minims;
Sweet Oil of Almonds	...	...	15 grammes;
Gum Arabic	...	...	15 grammes;
Cherry Laurel Water	...	...	4 grammes;

Distilled water enough to make the mixture up to 120 c.c. Mix.

Dr. Marfan (*Rev. des Mal. de l'Enf.*) states that bromoform is well borne by children. To children under five years of age he gives four drops of the drug for each year of the child's age. From five to ten years he gives twenty drop doses. He, however, says that he begins with small doses, two or four drops a day, and gradually increases the amount until the maximum doses are reached.

M. Renault rapidly increases the dose from as many drops daily as the child has years of age, until almost toxic effects are produced. He has given as much as one hundred drops daily to a child of three years old; the initial daily amount in that case was twenty drops.

[These doses are greatly in excess of those prescribed in this country, and are not such as we would recommend.]

ECLAMPSIA.

Dr. Rayen, of the Lying-in Hospital, Cologne (*Mon. f. Geburtst. Gyn.*) had 50 cases of eclampsia in 4,250 cases of labour, of these 43 were in primipara, and in the majority of them the patients were not young. Six were carrying twins. All suffered from albuminuria. He concludes that each case requires individual treatment. That most generally useful consisted of warm baths, and bleeding followed by saline rectal injections; or, when the os was rigid, incising it and rapid delivery.

THE VAPOUR OF BOILING WATER IN GYNÆCOLOGY.

Dr. Labusquiere (*Ann. de Gyn. et d'Obst.*) writes:—"The priority of the use of the vapour of boiling water in gynæcology is due to Sneijreiff. In 1893, the Russian surgeon extirpated a cyst from the liver, whose base was four finger widths broad. He applied the actual cautery to the base of the tumour, but it failed to stay the bleeding, which came from a point of hepatic tissue. The bleeding continued until he applied the epiploon and tampon on the raw surface of the gland. Persuaded of the insufficiency of the ordinary styptics in operations on the liver, he thought of the styptic properties of steam which he employed as a caustic and hæmostatic for the

eight years previously in gynecology. After dilating and scraping the neck of the womb, he introduces into its cavity a fenestrated catheter whose extremity is perforated by numerous small holes. This catheter is connected by tubing with a vessel of boiling water. The action of the steam is continued for one minute and a half, sufficient for the cauterisation and styptic action of the vapour. From experiments on extirpated uteri he found that the immediate action of the steam was to scald the interior and cover it with a whitish skin. The phenomena of decomposition, of putrefaction, of abnormal sensibility of the mucous membrane were not present. Vapour of boiling water acts as a caustic, styptic, anæsthetic, and as an antiseptic. After Snejireff as an advocate for the treatment is Ludwig Pincus who did much to popularise the use of the remedy.

In 1895 Pincus (*Cent. f. Gyn.*) published his first article, "The Therapeutic Use of the Vapour of Boiling Water," giving his experience of the remedy in the following cases:—

1. Case of cancer of the body of the uterus, inoperable. Symptoms: pains intrapelvic intense, metrorrhagia, fœtid discharge.

2. Endo-metritis, three cases, hyperplastic, no complication, menorrhagia.

3. Five cases of cervical endometritis, with erosion of the vaginal portion of the neck; leucorrhœa. The results were very satisfactory.

1. In the case of cancer, the moment in which the vapour came in contact with the uterine surface, there commenced to flow from the neck of the womb a quantity of blood and blood-stained fluid, mixed with detritus and clots. At the end of a minute and a half the catheter was withdrawn. It was found coated with dark coagula, very sticky, which blocked the finer holes in the instrument. Immediately afterwards the bleeding and the flow of fœtid matter ceased, and did not occur again until eight or ten days afterwards.

2. In the cases of endometritis the results were also satisfactory. But in one of them, in which no complication existed, the treatment was followed by intense uterine colic, which did not cease until the womb was coacinated.

The results, otherwise favourable, observed in the two remaining cases of endometritis were too recent to allow of our forming an opinion as to the permanent effect; withal the author recommends the treatment.

Dr. Labusquiere considers the use of the vapour of boiling water is of great therapeutic value in puerperal endometritis. The infectious germs are destroyed; the lymphatics and veins are obstructed by thrombi.

In 1896 E. Kahn published a work on the employment of the vapour of boiling water in puerperal endometritis. Kahn begins with steam of a temperature of 100° C., which he employs for two minutes at a time, and then he slowly raises the temperature to 115° C., which he applies for fifteen seconds, or, in some cases, for one minute. The more marked the action, the better have been the results.

The action of the steam was in general very slightly painful, a few women complain of pain on the first contact with the vapour.

At first the steam produces dilatation of the womb, this is, however, quickly followed by firm contraction.

No unpleasant effect has followed the treatment in Kahn's cases.

Dr. Labusquiere, from his personal experience, states that the patients experience from the treatment a great alleviation of suffering, which he ascribes to the lessening of the sensibility of the endometrium. The womb always contracts more energetically, and the inoculation is more rapid than in normal cases. It is necessary in the application of the vapour to consider the condition of the uterine wall; the more lax and feeble the wall the greater the necessity of a higher temperature of the steam. The existence of suppurative inflammation in any of the parts of the womb contraindicate the use of the remedy, which, under such conditions, would give rise to violent uterine contractions.

When portions of the after-birth, or portions of foetal issue, coagula, and so forth, it is absolutely necessary that they be removed either by the finger or curette

before the vapour treatment is commenced, lest the vapour would hasten the decomposition of the tissues and increase the danger.

After the foreign bodies are removed the action of the steam favours the formation of a pellicle of sterilised tissue which forms a protective covering for the mucous membrane, excluding the pathogenic germs from the womb walls. A few days afterwards the cavity should be syringed out with a weak solution of an antiseptic in warm water. The author favours chlorinated soda. He gives the following illustrative case:—H., æt. 38, in her fourth labour on April 22nd last. Three days afterwards her temperature was 102·8° F.; pulse, 102. The womb reached as high as the navel and was painful. The secretion was very fœtid. Scraping the womb got rid of fragments of the after-birth. Result no improvement; irrigation and scraping also failed to benefit the patient. Temperature 103·1° F. Secretion very fœtid.

On May 6th the vapour of water at 105° C. was applied to the inside of the womb for fifteen seconds. The patient did not complain of pain. The following day vapour of a temperature of 112° C. was applied for half-a-minute. Temperature during the night fell to 102·5° C., fœtor of the discharge. Two days later the temperature reached normal. Rapid involution followed, and the patient was well on the twelfth day.

The author concludes that the treatment is worthy of trial, as it has been efficacious after other well-known remedies have failed; it was beneficial even in cases in which it was not tried until late in the treatment. It should not be used if purulent inflammation of the annexes is present; if foreign tissues are in the womb; if the toxic condition is of a general and not of a local origin.—*El Siglo Medico*.

Clinical Records.

WESTMINSTER HOSPITAL.

Fracture of the Base of the Skull—Meningitis—Proptosis with Chemosis—Operation—Specific Treatment—Recovery.

Under the care of Dr. MURRELL.

L. E., a married woman, æt. 38, was admitted on February 6th, 1900, with the following history. On the third or fourth Sunday in October, whilst on a visit to her married daughter, and in a house with which she was not familiar, she misjudged the length of the landing and fell downstairs, striking her head violently against the wall. She was picked up insensible and remained in this condition for five days. She was told that there was bleeding from the mouth and ears. On regaining her senses she found that she was unable to move the left side of the face and to speak distinctly. On attempting to walk she could move her legs readily, but she was uncertain in her movements, and staggered from side to side. Her hands and arms were unaffected. About a month before admission she experienced sharp shooting pains in the left eye, and a few days later noticed that that eyeball seemed more prominent. The condition gradually got worse, and she came to the hospital.

On admission it was found that on the right side there was paralysis of the 6th, on the left there was paralysis of the 7th, with complete loss of hearing. The eyeball on the left side was very prominent, and in addition to the proptosis the movements of the eyeball were much curtailed, and there was extensive chemosis of the lower palpebral conjunctiva. There was no optic neuritis. There was no paralysis or loss of power in either the upper or lower extremities.

This combination of symptoms was by no means easy to explain. She had paralysis of the 6th on one side, and paralysis of the 7th and of the 8th, probably of both branches, on the other, and in addition to this there was the proptosis. This clearly could not be accounted for by any one single cerebral lesion. The most probable explanation seemed to be that as the result of the fall

she had fractured the base of the skull and that this had been followed by basal meningitis. The difficulty in walking was due to the injury to the 8th. It will be remembered that the 8th, or auditory nerve consists of two sets of fibres—the cochlear, which subserves the function of hearing, and the vestibular, which supplies the vestibule and semicircular canal, and is the nerve of equilibration. The proptosis which came on later than the other symptoms was evidently an independent affection, and was due to a neoplasm. What was the exact nature of the new growth was not quite clear, but the probabilities were in favour of its being a syphiloma. There was no history of syphilis, but she had had eleven children of whom eight died young.

A few days after admission the patient having been placed under gas and ether by Mr. R. J. Stilwell, two linear incisions were made by Mr. Hartridge at the junction of the conjunctiva with the lower lid, and one at the junction of the conjunctiva with the upper lid. No pus exuded at the time, but after the application of fomentations there was some on the dressings. The chemosis rapidly subsided.

The patient was now placed on iodide of potassium, the dose being rapidly increased from 5 grains to a drachm three times a day. This caused her some inconvenience, but the treatment was kept up steadily for three weeks. The proptosis rapidly diminished, and by March 14th when the patient left the hospital at her own request, had practically disappeared. There was very little improvement in the facial paralysis, and there was no restoration in the function of the 6th and 8th. These nerves were evidently too deeply implicated by the meningitis for treatment to prove of any avail. The case is a curiously interesting one as a study of cranial nerve lesions.

Transactions of Societies.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, MARCH 16TH, 1900.

The President, Dr. A. V. MACAN, in the Chair.

EXHIBITS.

DR. SMYLY—(a) Ovarian Abscess removed by Coeliotomy; (b) Myomatous Uterus removed by Abdominal Hysterectomy; (c) Ovarian Cyst removed after four tappings.

ROTUNDA HOSPITAL REPORT.

Dr. PUREFOX thought the term "mixed" applied to accidental hæmorrhage had some advantages, but he was not prepared to defend it. He pointed out that when dealing with hæmorrhage in the sixth month of pregnancy it might be quite impossible to determine whether the placenta is low down or not. They examined the cases as carefully as possible, and the diagnosis in each case was confirmed. He observed that observation in the hospital for some years past had furnished them each year with accumulating proof that the use of the vaginal tampon in severe accidental hæmorrhage was a wise and judicious proceeding. They did not teach that it was a treatment applicable to every case of accidental hæmorrhage, for many cases met with can still be treated by assisting the uterus to contract, and then rupturing the membranes. The table showed that in only five cases did they consider the use of the tampon necessary. In regard to Dr. Smyly's charge against them of introducing a new and unwise treatment of puerperal eclampsia, he failed to see how he deduced from the narration of the case any grounds for suggesting that they have adopted a new mode of treatment. The case was briefly this:—The patient, a primipara, was admitted to hospital in a bad condition, with marked œdema and scanty, albuminous urine. She was far advanced in pregnancy. The treatment adopted had the effect of bettering the

condition to a large extent, so that the albumen almost disappeared from the urine. This improvement lasted only forty-eight hours, and in spite of the treatment the urine again became scanty and albuminous, and the swelling returned, and her condition was such that it appeared very likely eclampsia would supervene if treatment were not adopted. He still thought that the emptying of the uterus by the safest method was the proper proceeding. It was true that eight hours afterwards an eclamptic fit occurred, which Dr. Smyly attributed to the operation, but he did not agree with him. The condition of the patient was such, with the distension of the labia, that the skin covering one gave way. It will not be hard to understand that under these circumstances continuance of pregnancy was the last thing to be desired. He shared to the fullest extent Dr. Smyly's feelings as to the urgent need for obviating the grievous results to patients in this country from the ignorance and stupidity of midwives. He was not sure that the establishment of a new register would deal with the difficulty or lessen the risks in any appreciable degree. In some of the forceps cases the child's head had not passed the brim. With reference to the alleged abuse of the curette he thought many cases of abortion could be treated with the finger. It was true that in the hospital the curette was used in a number of cases; but most of the cases coming in were cases of incomplete abortion, with a discharge for days before, and in that condition they were not beneficial occupants of a ward where there were other patients. Dr. Macan had suggested that the forceps was used too frequently; but he referred him to the report of the hospital, which he published in 1889, dealing with 1,000 cases. The percentage of forceps cases was five distinctly above the percentage in our report. Regarding the occurrence of icterus, Dr. Macan thought the percentage in infants ought to be 80. The report gave it as between 15 and 20. He could not concede that these returns are not as accurate as any similar ones. As to the use of the bag in placenta prævia, the results in the hospital are so good that he did not feel tempted to change their present mode of treatment for any other.

Dr. MACAN read a paper on Atmo-kausis and Zesto-kausis.

Dr. HASTINGS TWEEDY thought the instrument had a great future before it. If even a part of what was claimed for it was realised it would almost revolutionise the treatment of endometritis. When used for septic endometritis, where the germs had penetrated to a considerable degree, he feared if the cauterisation could destroy these germs, it would destroy the whole endometrium.

Dr. JELLETT said that, judging from the effect of steam on the hand, a 10 or 15 second application would not give in any ordinary case a very deep amount of cauterisation of the uterus. The instrument would be an adjunct to the curette, but he could see no ground for supposing that it would take its place. If it were a good cauterising agent why should it not be used for a short time after the curette, and avoid bringing on a slough in parts of the uterus that had been very much thinned? Even if there were a slight amount of danger attaching to its use, he thought, in cases of hæmophilia, it might be the means of saving a woman from the loss of her uterus.

Dr. MACAN, replying, said he did not intend to give an opinion of the instrument. He had given the results of some 800 cases from the reports of the most eminent gynaecologists in America and Germany. In a very short time the instrument had met with an extraordinary reception abroad, and was looked upon as one of the best additions to our therapeutics. The depth of cauterisation was regulated by the time the instrument was allowed to act. If it were desired to close the cavity altogether it would probably require two operations. As to sterilisation of the mucous membrane, Dr. O'Sullivan had told him that he had used superheated steam at 110° and found it did not kill streptococci.

The Section then adjourned.

HARVEIAN SOCIETY OF LONDON.

MEETING HELD THURSDAY, APRIL 5TH, 1900.

Mr. W. H. LAMB, M.B., President, in the Chair.

DISCUSSION ON THE DIAGNOSIS AND TREATMENT OF CHRONIC PURULENT NASAL DISCHARGES.

MR. EDMUND ROUGHTON, in introducing the discussion, said that a diagnosis should be sought for by means of (1) Questions; (2) Rhinoscopy; and (3) Certain special methods of examination. 1. Questions.—By questioning we ascertained the nature of the discharge, whether it was unilateral or bilateral, continuous or intermittent, affected or not by change of posture, offensive to the patient or to others, and whether it was accompanied by pain or headache. 2. By rhinoscopy, aided with the nasal probe, we endeavoured to localise the situation of the pus, at the same time directing attention to the occurrence of polypi or granulations, atrophy of the mucous membrane, crusts, ulcerations, necrosis, adenoid growths, nasal obstruction, and the possible presence of a foreign body. 3. Special methods of examination were employed when the information gained by questions and by rhinoscopy led to a suspicion of disease of the accessory sinuses. Mr. Roughton limited his remarks on treatment to diseases of the accessory sinuses. In antral empyema the indications for treatment were (a) removal of cause, (b) evacuation and drainage of pus, (c) antiseptic irrigation and removal of morbid material when present. These indications should be carefully borne in mind; thus it would be futile to irrigate the antrum through the nose whilst it was allowed to be continually re-infected by carious teeth; nor could we expect to cure by drainage when the mucous membrane was polypoid or the bony walls carious. On the other hand, needless damage would be inflicted by scraping out an antrum which was simply acting as a pus receiver to a diseased frontal sinus. In most cases the treatment should be commenced by alveolar drainage, using a good sized tube. When this method failed after a fair trial we must resort to the radical operation through the canine fossa. The treatment of empyema of the frontal sinus was divided into intra and extranasal. The former comprised removal of the anterior part of the middle turbinate and irrigation of the cavity through the infundibulum. These methods should have a fair trial and should always precede extranasal treatment. The external or radical operation was recommended as being free from danger and offering a very good prospect of cure at the expense of a scarcely visible scar. The operation should be urged when there was pain or other evidence of imperfect drainage. The treatment of ethmoidal suppuration consisted in removing the middle turbinate and scraping out the affected cells, taking care not to transgress the anatomical limit of the lateral mass of the ethmoid. Any direct operative attack upon the sphenoid should only be undertaken after most careful consideration.

Dr. HERBERT TILLEY agreed with Mr. Roughton that the pain of chronic suppuration of the accessory cavities was due to accumulation of pus under pressure, and not to inflammation of the nerves in the walls of the sinuses as had recently been suggested by Mr. J. G. Turner. In support of this opinion cases of antral and frontal sinus suppuration were cited in which the pain disappeared immediately free drainage had been secured by removal of a tooth, irrigation of the antrum from the nose, or removal of the anterior half of the middle turbinate and of obstructing polypi and granulation from the region of the middle meatus. The mucous membrane cushion between the mid-turbinate and the outer wall of the nose was not pathognomonic of antral suppuration; it occurred most frequently in conjunction with that disease, but was sometimes present in other chronic inflammatory conditions which were specially localised in the mid-meatal region. In testing for pus in the antrum by transillumination, the patient's comparison of the subjective sensation of light in the eyes was sometimes of more value than the surgeon's

comparison of the facial illumination. The speaker strongly supported alveolar drainage as, at any rate, a preliminary measure in all cases of antral suppuration. It was a simple mode of treatment and often cured cases; furthermore, it afforded the patient the easiest means of treating himself in the intervals between his visits to the surgeon. Puncture in the canine fossa he had relinquished because of the inflammatory swelling of the soft parts produced by the traumatism in which the head of the drainage tube was very apt to be lost, while drainage did not occur from the lowest part of the cavity. Intranasal drainage is advisable where alveolar puncture would necessitate the removal of a sound tooth—an uncommon contingency. Intranasal drainage necessitates a more serious surgical procedure, and many patients had great difficulty in finding and catheterising the naso-antral opening. To obviate this difficulty, the anterior end of the inferior turbinate may be removed. If the alveolar method fails after a fair trial, as a general rule the radical operation described by Mr. Roughton may be advised. Failure to cure by this means is sometimes due to insufficient curettage of the upper and inner region of the antrum, which is cellular in structure and closely associated with the anterior ethmoidal cells, which were often diseased. Dr. Herbert Tilley had tried irrigation of the frontal sinuses in a few cases of empyema, but they were only benefited and not cured. The solutions included boracic and carbolic acid lotions, peroxide of hydrogen solutions, and iodoform emulsions. There were undoubted risks in the radical operation, and at least six fatal cases of septic osteomyelitis had been recorded, but the present methods of treatment reduced such risks to a minimum. The speaker advised (1) preliminary intranasal treatment involving removal of the mid-turbinate and all chronic inflammatory products from the mid-meatal region; (2) providing free drainage into the nose at the radical operation; (3) removal of all degenerate mucous membrane from the sinus by curettage and then frequently packing it until a healthy mucous membrane is produced. The external wound is then allowed to close, and remarkably little scarring is produced. If the sinus is small the whole anterior wall is removed and the cavity obliterated. If the sinus is a very large one only a portion of the anterior wall is removed, and the cavity treated as already stated. In dealing with suppurating ethmoiditis thorough intranasal treatment should be exhausted before doing an external operation. By the adoption of the former method a cure may sometimes be brought about, but, even failing this, the improvement is sometimes so marked that the patient will consider the disease practically cured.

Dr. SCANES SPICER, Dr. DUNDAS GRANT, Dr. WM. HILL, Dr. ST. CLAIR THOMPSON, and Dr. LACK also took part in the discussion.

Mr. ROUGHTON agreed with Mr. Dundas Grant that dulness on transillumination was caused more by thickening of the antral lining than by pus in its cavity, and that consequently absence of shadow should be regarded rather as a favourable prognostic than a negative diagnostic sign. The fatal results following operation on the frontal sinus referred to by Dr. Tilley and Dr. Lack were more often due to the disease than the operation, when really due to the operation they were attributable to two causes—viz., sepsis and absence of efficient drainage.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD THURSDAY, APRIL 5TH, 1900.

MR. EDGAR BROWNE, F.R.C.S.E., President, in the Chair.

CASES.

Dr. STOPFORD TAYLOR exhibited a case of dermatitis repens involving the back of the hand and fingers. The disease had been arrested and was proceeding rapidly towards recovery under a dressing of powdered iodoform forcibly rubbed in with the finger. Also a case of tuberculous ulceration of the skin on the right side of the neck, corresponding to the shirt collar band. The ulcer

was six inches in length and two in width, and had spread rapidly, having been in existence but four months.

Dr. W. J. ALLEN related a case of embolism of the mesenteric artery occurring in a patient after a normal labour, and associated with mitral stenosis. Symptoms of collapse came on some time after delivery. There were no signs of hæmorrhage or rupture of the uterus to account for such collapse, and the condition was discovered on examination after death.

Dr. T. R. BRADSHAW showed a woman, æt. 30, the subject of diffuse scleroderma. The condition was almost universal, but affected the hands and forearms to an extreme degree, the fingers being hide-bound and almost fixed in a position of slight flexion. The affection seemed to involve the sheaths of the flexor tendons as was shown by the existence of creaking on passive movement. The onset was acute a year ago, and was marked by pain, redness, and swelling in the fingers.

Dr. F. H. BARENDT considered this case to be typical of the disease; the pathological process involved brought scleroderma and Dupuytren's contraction of the palmar fascia, sclerodactyly, and those rheumatic nodules known sometimes as Heberden's nodes into the same category. He suggested the administration of thyroid extract rapidly pushed till physiological reaction occurred. The prognosis was not always unfavourable; in fact, cases were recorded where the disease not only was arrested but a certain degree of involution took place.

Mr. E. W. MURRAY showed a man, æt. 40, upon whom he had operated for aneurism of the femoral artery in Hunter's canal. The aneurism was of recent date and was increasing; it would be twice as large a swelling as would be caused by a substance the size of the closed fist buried in the thigh muscles. The general health was good, and there was no sign of disease of the vascular system. The operation consisted in excising the sac as far as possible after ligation of the artery above and below. The excision was only partial owing to extensive gummatous infiltration of the adjacent structures. The man has resumed his work of ship's engineer.

Mr. K. W. MONSARRAT remarked that the unusual site of the aneurism was probably to be explained by the affection of the arterial walls having been secondary to the tertiary syphilis of the muscles in the vicinity and a direct extension from the latter.

Dr. T. R. GLYNN exhibited a man, æt. 30, with bulbar paralysis. The duration of the disease was sixteen months. The family history was good, there was a history of ague, but not of syphilis. The affection commenced with speech trouble, followed, in three months, by difficulty in deglutition. The tongue was completely paralysed, the seat of fibrillary tremors, and atrophied. Speech was lost; he emitted a laryngeal sound of nasal quality in answer to questions. The lips were partially separated and saliva escaped, the mouth was elongated laterally owing to the action of the muscles of expression. The palate reflex was absent, the pterygoids were paralysed, the temporal and masseter muscles normal, vocal cords normal. The case was one of amyotrophic muscular atrophy—there being atrophy of some of the intrinsic muscles of the hands, presence of masseteric reflex, over-extension of great toes, exaggerated on producing plantar reflex.

Mr. GEO. G. HAMILTON showed a patient upon whom he performed the operation of Colectomy for Carcinoma of the Sigmoid Flexure, and advocated the use of Murphy's button in such cases, with special reference to the correct application of the button.

Dr. GLYNN read a note of a case on the use of Thyroid Extract as an Emmenagogue. He had met with many cases of young girls, who through some slight developmental change, had a temporary amenorrhœa, or a delay in menstruation; and in such cases the administration of thyroid extract in doses of gr. $\frac{1}{4}$ once a day, generally given at bedtime, proved sufficient to re-establish or start the function of menstruation.

Dr. WM. CARTER observed that the case mentioned by Dr. Glynn was those of young people, and from the well-recognised influence of the thyroid secretion on developmental changes, he thought that its effect in such might be different from those in people of mature

age, as it had been established by Chéron, and his results had been copied into the most recent works on therapeutics, that a marked effect of thyroid extract was to diminish, and even check, all forms of uterine hæmorrhage.

Drs. Buchanan, Barr, Gemmell, and Wilson also took part in the discussion which followed, and Dr. Glynn replied.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, April 14th, 1900.

PLEURISY IN APPENDICITIS.

At the meeting of the Académie de Médecine, M. Dieulafoy called attention to a rather frequent complication of appendicitis, which was that of infection of the pleura, and to which he desired to give the name of appendicular pleurisy. The first point to observe was the way in which the appendicular infection attained the cavity of the pleura. An attentive study of the lesions in the cases which he observed proved to him that the appendicular pleurisy was the result of propagation by the lymphatic tract. In a general way, appendicular infection, become peritoneal, gained the right hypochondria, traversed the diaphragm, and invaded the pleural cavity. It was consequently an infection of an ascending type.

The pleural complication appeared generally from the eighth to the fifteenth day after the *début* of the appendicitis. The infection commencing only its ascension after the third day, the surgeon had time to operate; in removing the seat of infection, he suppressed at the same time all cause of secondary infection and cut the evil at the root. Every appendicitis acute, slight or intense, could be followed by appendicular pleurisy. That manifestation which was situated habitually on the right side was preceded by heptophrenic symptoms; pain in the right hypo-chronic irradiation towards the shoulder, dyspnoea, the volume of the liver apparently increased, &c. Those symptoms were explained by perihepatitis and subphrenic empyema which preceded the pleural infection. The pleural symptoms, such as pain in the side and cough, appeared in their turn and were confounded with the heptophrenic phenomena.

Appendicular pleurisy not observing always the same evolution, it was important to study its different characters. Habitually it was putrid and the effusion was extensive. Besides the usual signs of pleurisy, dulness, absence of vibrations, souffle, &c., there is observed sometimes œdema of the thoracic walls. More or less frequently percussion denotes at the apex of the lung exaggerated tympanum, and auscultation revealed signs of pneumo-thorax.

The first idea that came to the mind was the presence of tuberculous perforation of the lung, the pneumo-thorax by perforation having for a long time occupied such a preponderating situation that one hardly thought of the possibility of a pneumo-thorax by putrefaction. But whether there existed pneumo-thorax or not, from the fact that a pleurisy developed rapidly in the midst of grave symptoms, the nature of the effusion should be examined. To this end an exploratory puncture should be practised, and if the liquid withdrawn was serous and fetid, empyema should be done immediately.

Such was the appendicular pleurisy as it presented itself habitually. Sometimes the infection was but slight, the liquid was not abundant and became absorbed spontaneously.

RENAL TUBERCULOSIS.

M. Pousson communicated to the Société de Chirurgie the result of twelve cases of renal tuberculosis complicated with secondary infection, for which he operated. Five times he performed nephrotomy, with one death, and four temporary cures, and seven times nephrectomy, all successful. The results of the last series of surgical interference proved the superiority of nephrectomy over nephrotomy. He considered it needless to say that the nephrectomy was always extra-peritoneal, and he took care to complete the extirpation of the kidney by resection of the ureter.

M. Tuffier remarked that the treatment of tuberculous kidney should vary according to the patients. It was thus that nephrotomy was the method of choice in cases of retention complicated with pyelonephritis. As to ureterectomy, it was not necessary when the lesions of the kidney were limited, and that the ureter had undergone fibrous transformation.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, April 14th, 1900.

RESULTS OF MODERN SANITATION IN BUDA PEST.

THIS week Körösy has given us a few figures of some interest concerning the progress of Buda Pest in sanitation during the last thirty years. The mortality for the last twenty-two years from 1874 till 1896 has fallen from 44.5 per 1,000 to 24.2 per 1,000, or about a half. From 1886 to 1890 inclusive the average death-rate during the five years was 30.5, while the birth-rate was 37.4 per 1,000, or 6.9 of a natural increase. These figures prove that Buda Pest is a fairly healthy town notwithstanding the epidemics incidental to its position. The natural increase is worthy of note, which is 6.9 per 1,000; Strasburg having 5.8; Königsberg 3.9; Liverpool and Bradford 5.3; and Manchester 4.7.

The infectious diseases death-rate from 1882 to 1890 was 3.6, of which tuberculosis formed the major part, although this has greatly improved in recent years. From 1875 to 1881 the mortality from tuberculosis alone was 847 per 100,000. During the decennium 1881-1890 it was 758, which has now fallen to 520 per 100,000, or 0.5 per 1,000. Between 1888 and 1890 the deaths from pulmonary diseases was 30 per cent. less than in 1875. His statistics tend to show less tuberculosis among the Hebrew than among Catholics, Lutherans and Calvinists, but when we compare the nature of occupation the comparison is not tenable. In every 1,000 there are 168 Catholics, 125 Lutherans, 148 Calvinists, and only 68 Jews returned as labourers, while of the four faiths merchants or shopmen are given as 20, Catholics 20, Lutherans 36, Calvinists 20, and 131 Jews. This occupation is also favourable to the Jew.

JUVENILE OSTEOMALACIA.

At the "Gesellschaft der Aerzte" Latzko exhibited a female, æt. 22, who had suffered from osteomalacia for many years, but by the use of phosphorated cod-liver oil had been quite cured. A year ago she was operated on for the removal of the foetus by the Cæsarian section.

She bore the anæsthetic badly, and suffered after the operation from pains, vomiting, and general derangement of the alimentary canal. She made a rapid recovery after the removal of the dead foetus and now all the intestinal disturbances have disappeared.

THE LATE PROF. JOSEF GRUBER.

Prof. Josef Gruber, of European fame in aural surgery, whose death has already been briefly announced in your columns, was born in 1827 in Bohemia. He came to Vienna, and graduated as Doctor of Medicine in 1855. In 1863 he was appointed Docent "für Ohrenheilkunde." He completed a text-book on the subject in 1870, and since that time has written many monographs. He was advanced to the professorial chair in 1893, and was the founder of the Austrian Otological Society.

THE LATE PROF. HOFMOKL.

Another of Vienna's great surgeons has passed from among us. Hofmokl was born in Brzezany of Galicia, where he received his early education, but graduated at the Vienna University, and in 1868 was appointed assistant surgeon to Dumreich's clinic, and in 1871 was appointed docent in surgery, in which capacity he wrote a good deal on operative surgery. In 1885 he was raised to the third chair of surgery of the Vienna University, which he held till December, 1898, when he was suddenly seized with a paralytic stroke, from which he slightly recovered. He afterwards went to Abbazia to reside, where he had the title of Hofrath conferred on him. The change of residence, however, was without any beneficial effect on his health, and he died at a comparatively early age.

Continental Notes.—The Savoy Spas.

[FROM OUR SPECIAL CORRESPONDENT.]

No. I.—AIX-LES-BAINS.

THIS "Queen of French Spas" had last year the most successful "Season" it has yet known. It has made every preparation this year to excel "the record." Its principal hotels opened last week (unusually early), and its Casino concerts commence April 20th.

Notwithstanding the cold weather still lingers along the Riviera, fashion will have its sway; and as it has become "the thing" to quit the azure coast in April, many are going thence this month to the Savoy Spas. There are a choice of good routes from the Riviera to Aix-les-Bains. From Genoa *via* Milan to the Italian Lakes and through the St. Gothard Tunnel to Lucerne, Berne, Lausanne and Geneva. (At Milan is the excellent Hotel Continental, and at Lucerne, the supreme of Swiss hosteleries, the Schweizerhof, for those who wish to tarry by the way.) From the places west of Genoa, a shorter route is *via* Savona, Turin, and the Mont Cenis Tunnel direct to Aix-les-Bains. From Nice, Cannes and Hyères, the route usually taken is by Marseilles and Lyons. For those who have the time a more picturesque route is from Marseilles through Aix-en-Provence, and its antiquarian surroundings, concerning which I wrote in THE MEDICAL PRESS AND CIRCULAR, of March 28th.

In May from Cannes and Nice several livery stables send their carriages and horses for the summer season, over the mountains to Aix-les-Bains, Evian, Lucerne, &c. Travellers who have leisure to devote four or five days to

the trip, find this a convenient and economical way of securing a most pleasant mountain excursion. The hotel accommodation on this carriage route is modest but comfortable. I may add that from Geneva are two railway routes to Aix-les-Bains. One *via* Culiz Junction (on the Geneva to Lyons railroad), the other rather longer in time *via* Annecy. Annecy is the lake, the loveliest in France; the romantic Georges du Fier; and a capital hotel, "The Angleterre." Speaking of hotels, in THE MEDICAL PRESS AND CIRCULAR ("Notices to Correspondents") of April 4th, two admirable ones are mentioned, the "Grand Hotel d'Aix" and "The Albion" at Aix-les-Bains. Besides these are many others of all classes; for Aix provides accommodation to suit all purses. It is verily "a town of hotels and pensions" of very desirable apartments; also notably the "Maison Damesin," and similar houses, with or without kitchens. The Aix waters treatment and climate being so beneficial to invalids and convalescents, they should not be limited to the wealthier classes; the too general prevalence is to be regretted of the idea that none others are welcome there. Aix admires fashion, and amply provides luxuries for the wealthy; but within its hospitable boundaries there is abundant room, and provision made also for those who have to "consider ways and means." In the sultry months of July and August when (as is the wont on the Continent) the Spas are crowded, fashion and its votaries are very prominent at Aix, but in the preferable months of May, June and September ("the English months" *par excellence*) life at Aix runs more quietly. You may then live pretty much as you please. Picnic in the woods, "laze" on a balcony, live in a boat tied to the lake shore, explore mountains and camp among resinous firs, learn languages, flirt, gossip and quarrel, or (what is far more difficult) "seek peace and pursue it!"

The Operating Theatres.

GUY'S HOSPITAL.

OPERATION FOR UNUNITED FRACTURE OF THE FEMUR WITH CONSIDERABLE DEFORMITY AND SHORTENING. — Mr. ARBUTHNOT LANE operated on a miner, *æt.* 45, who a year before had sustained a fracture of the femur produced by a fall of rock upon him. The leg was very considerably shortened and bowed, owing to the upper fragment projecting outwards at an angle of 50° to the vertical, the upper extremity of the lower fragment lying on its inner side and overlapped by it to the extent of 2½ inches; there was an abundance of callus connecting the ends of the bone, but not uniting them sufficiently securely to prevent movement between the fragments, or to enable the patient to bear his weight on the limb. Mr. Lane exposed both fragments freely by an incision about nine or ten inches in length, and freed them of all intermediate callus; by freeing them extensively, by exerting considerable traction on the foot, and by means of levers between the bones, the greater part of the shortening was reduced. The ends of the bones were awn through at an angle of 45° to the vertical, and their surfaces brought into accurate apposition, and retained there immovably on one another by means of screws. The shortening which resulted was equal only to the por-

tion of the shaft which had been removed to obtain the necessary oblique surface of attachment which was the only form that would have assured security of connection in this case. Mr. Lane pointed out the enormous mechanical advantage of the screw in operations of this sort. In a very large number of ununited fractures in the adult on which he had operated using the screw as an approximating and retaining medium, he could only remember one in which he had failed to obtain a successful result; that was in the case of a man who had sustained a compound ununited fracture of the humerus, and who had been previously operated upon on nine occasions without success, a flail-like condition of the parts resulting in each instance. At the time Mr. Lane saw him, there only remained of the humerus two short conical stumps; he made two attempts to retain these wasted processes of bone in apposition by means of a screw, but on neither occasion did he succeed in bringing the ends into anything like satisfactory connection; in neither instance was there the slightest evidence of repair.

OPERATION FOR DILATATION OF THE PYLORUS.—The same surgeon operated on a man, *æt.* 28, who had for some years suffered from symptoms of pyloric obstruction. The stomach was exposed by a vertical incision; the pylorus was found to be constricted so as hardly to admit the point of the little finger. By involuting the stomach wall he gradually dilated the pyloric orifice by forcing the little finger slowly but forcibly through it. The other fingers were then introduced in sequence, either through the prolapsed stomach wall or through the intruded duodenum till it was possible to introduce the point of the thumb. When the thumb could be introduced freely two fingers were inserted, and the pylorus still further dilated. Neither the wall of the stomach nor that of the duodenum was injured during the dilatation. The wound in the abdominal wall was then closed. Mr. Lane hoped that by means of this simple procedure the patient would be relieved of his obstruction. He pointed out that this method of operating obviated the slight additional risk which would accompany a cutting operation on the stomach, and which he considered might not have given such a satisfactory result.

WEST LONDON HOSPITAL.

LIGATURE OF THE FEMORAL FOR POPLITEAL ANEURISM.—Mr. SWINFORD EDWARDS operated on a man, *æt.* 30, who had been admitted with a pulsating tumour in the right ham, having a recent history of three weeks. The tumour was getting larger and causing intense pain. It occupied the upper half of the popliteal space, extending under the Adductor magnus. Compression of the femoral stopped all pulsation in the swelling.

A question of excision was raised, but Mr. Edwards considered that ablation of an aneurism so high up in the popliteal space would be an unusually difficult operation, and he thought that by ligature of the artery an equally good if not better result would be obtained.

It was therefore determined to tie the femoral at the apex of Scarpa's triangle. The operation was performed in the usual way. An incision was made commencing a hand's breadth below Poupart's ligament. The inner border of the Sartorius was immediately struck and the muscle pulled slightly to the

outer side. A few small blood-vessels, running straight backwards, pointed to the site of the femoral vessels. The sheath was opened and the artery ligated in two places about one inch apart. The vessel was then cut between two ligatures, retraction taking place to the extent of half an inch. The wound was closed and the leg bound up in cotton wool. Mr. Edwards remarked that he thought that in these cases of ligation of the femoral a great point was to divide the artery between two ligatures and not simply to ligate it, for, as was shown, retraction when the artery was divided was a marked feature, thereby giving greater security against any secondary hæmorrhage. Contraction and retraction, he said, are both ensured by this method, but by simple ligation only contraction takes place, therefore one is not likely to get such a complete sealing of the vessel and such a complete obliteration of the artery.

The patient after operation rapidly lost his pain; the aneurism exhibited no pulsation a week after operation, and is getting rapidly smaller and harder.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, APRIL 18, 1900.

THE FUTURE OF ASYLUM SERVICE.

[CONCLUDING ARTICLE.]

To those who have been in the whirl of change which has taken place in asylum administration during the last decade, it will be apparent that the subject of asylum service would be "The Prince of Denmark" with Hamlet left out, if we said nothing about the special training of asylum nurses and attendants. It is well on for twenty years since this subject was introduced and this systematic training was first properly organised and started at the Bothwell Asylum. The idea was at first a tender shoot, which received anything but kindly treatment from the

winds of alienist opinion; but it grew, and strengthened with its growth, and has become an accomplished fact, and a recognised factor of the well-being of the insane, and a strong recommendation to the asylum service. With the conception of training, and the modern hospital development of asylums, has come the idea that mental nursing is a branch properly so-called of general nursing, and that mental nursing requires to be supplemented with a general physiological and nursing education. From this has grown the idea that hospital trained nurses are an acquisition to asylum service, and the idea has gone so far that some superintendents insist on having their matrons and assistant matrons, and what they call "lady supervisors," trained nurses taken from general hospitals. This is an idea which at the first blush seems very commendable, and it has been taken to very cordially in many directions, but there is a danger that the delicate plant which was not too kindly treated by the winds of adverse criticism in the early days of the mooted idea of special training, may now be kept too much in the hot-house and forced by æsthetic zeal into a sickly plant, which will die of inanition in the end. What is wanted at the present stage of asylum management is a straight look into the face of facts, and a common sense view of the real requirements of asylum service as regards *personnel* and training. Those who go in so strongly for the general hospital training as a *sine quâ non* forget the fact that asylum life, asylum ways of looking at things, and asylum patients are, to a very large extent, essentially different from those features of the general hospital system. The mental proportion in the equation is much more considerable than the physical and you cannot treat the insane in detail as you would in hospitals. If that were so why are asylums so very different in their construction, arrangement, and management from hospitals? Even when an insane person becomes physically disabled either from disease or injury, that insane person requires an amount of attention which is not necessary for a sane person. If the hospital treatment is a *sine quâ non* and essential, why are hospital patients when they become insane sent to asylums? Why do hospital authorities require special attendance on such cases by trained asylum nurses? Simply because the mental features occlude the physical, and call for most attention. If asylum superintendents would look at it from this point of view they would recognise that the asylum training is even more essential than hospital training, that both have their recommendations, but that the mental training should take precedence. In view of what has been stated regarding the preference of some superintendents for hospital trained nurses, it will not be surprising that many asylums of recent years have engaged matrons whose sole qualification has been that they were trained and duly certificated hospital nurses. In taking this step asylum superintendents and committees have been carried away with *a priori* ideas which were not correlated to actual experience of the real facts of the case, and the consequence is that, though perhaps some

superintendents have not seen it, or are blind to it, many of these matrons have been a failure. In this connection we have to consider two points, first, is this idea of hospital nurses in asylums prejudicial to the prospects of ordinary asylum nurses as regards promotion? and second, is it prejudicial to that proper understanding of the ordinary asylum nurses trials and difficulties, to that sympathy with the insane which are essential to perfect management of nurses and patients? The answer to the first question is in the affirmative, and so is the answer to the second. There can be no question of this that an hospital training alone is not fitted to adapt any one to fit into the particular idiosyncrasies of asylum life. The hospital nurse has her own lofty standard which is largely made up of the personal equation, and is not altruistic, so far as asylum nurses are concerned. Instead of adapting herself to the changed circumstances presented by an asylum, she tries to bend or break in these circumstances to suit her own views. She has, in short, begun her training at the wrong end. An ideal asylum nurse, assistant matron, or matron, is a woman with common sense, intelligence, and an average education, who has received her asylum training first and has grafted on it, an hospital training afterwards. She understands the insane as insane persons, as well as sick and hospital cases, she understands the particular character and point of view of the ordinary asylum nurse position, and where the mere hospital nurse would be constantly producing friction, because of lack of proper insight, the nurse who has also asylum experience will be exercising official tact and pacification instead. Reciprocity should exist between asylums and general hospitals, that is to say, asylums should give facilities for a short course of mental nursing to hospital probationers, and hospitals should give facilities for a short course of hospital nursing to asylum probationers. This would decidedly be to the advantage of all concerned. The average hospital probationer is a very useless individual for the first few months of her hospital life, while the average asylum nurse could give her points in housework and general administrative work. By such reciprocity as we have indicated the best interests of the insane and of asylum service will be secured.

CHILDREN'S HOSPITALS.

WE can understand well the sentiment that finds expression in subscribing to the support of children's hospitals. Many of the troubles of great cities appear to be due to avoidable causes, that is in respect of illness, and as the young cannot be accused of causing their own troubles more sympathy is naturally felt for them than for those who are better able to take care of themselves. The question, however, arises whether there is any advantage in having hospitals specially provided for sick children. Specialism of treatment of particular maladies or organs, such as for cancer or consumption, or for the eye, or the ear, is reasonable. In large general hospitals there are wards for children, for

ophthalmic cases, for gynecology, and possibly for infectious cases. To some extent we may trace the origin of special hospitals to the neglect on the part of the general hospitals to institute special departments where they seemed necessary. The physician or surgeon who is not a specialist is usually opposed to special departments which may remove from his charge cases that would be useful in the education of students, and which in private practice he would rather not lose. In the case of children, however, it seems doubtful whether it is wise to withdraw them from treatment in general hospitals, as a knowledge of children's diseases is so important to the general practitioner that we can easily understand the loss that is felt when a great hospital and school are deprived of a large number of cases for no particular reason, or no advantage to the public or the profession. Where a children's hospital is associated in some way with a religious society, and when there are those who will undertake gladly the nursing of children, when they are not fitted or disposed to do the same for adults, we can understand the support that will be given to such a hospital. When we consider that the great majority of sick children are provided with mothers, who are likely to be best fitted to nurse them, we may ask whether there are reasons in the crowded parts of great cities for relieving the mother of this charge. If a woman can employ her time to more advantage to herself and family in other work than care of her children it may be well to provide her with the means to do so. In great cities we fear that 50 per cent. of the cases brought to hospitals are simply the results of bad air, bad food, and other evils which the hospital cannot permanently relieve. Those cases which ought to be taken in and treated are mostly of a peculiar type, such as infantile paralysis, hydrocephalus, well marked rickets, and certain other medical and surgical cases which have an interest from their rarity. But to remove these cases from a general hospital where they could be quite as well treated and where it would be of advantage for students to see them is not judicious. If hospitals such as that in Great Ormond Street are really intended to supply the most crowded parts of London where the out-patient department is of more importance than the wards, it is well to consider whether the in-patient department would not give better results if situated in more open and healthy parts, especially as pure air is of enormous importance, and the danger of infection from outside influences would be eliminated. There is no doubt as to the wisdom of separating children from adults, and of providing special wards for them, as is now done at most of our great hospitals, for the children's sake as well as for the adults; and it would be well for the contributing public to encourage this as much as possible so that, as subscribers to a general hospital, they would have the privilege of sending children in, thus providing physicians and students with the means of studying a very important class of cases. It certainly does not appear to be desirable for physicians or surgeons

to allow age alone to constitute a specialty, though we are quite prepared to admit that special hospitals of certain kind are undoubtedly necessary.

DIPSOMANIA AND HYPNOTISM.

IN many ways the abuse of alcohol is one of the most serious forms of intemperance with which our modern civilisation is cursed. Not only does it play havoc with the moral and physical life of the individual, but it also blights the prospects of that portion of the rising generation unfortunate enough to be thrown beneath the shadow of this deadly upastree. Anything, therefore, that offers a reasonable chance of preventing or curing the craving for strong drink deserves careful investigation at the hands of scientific men, and above all of the medical profession, which is directly and continuously concerned with the results of alcoholism, acute and chronic, upon the human body. It was mainly due to the life-work of the late Dr. Norman Kerr that we have come to recognise inebriety as a malady that demands careful and accurate study. In our present stage of imperfect knowledge of data there is a wide field open to empirical remedies, and the "cure" of drunkenness has given rise to a large amount of quackery. It is with all the more pleasure that one welcomes an important contribution to the subject from so distinguished and competent an observer as Dr. Milne Bramwell, who last week delivered a lecture before the Society for the Study of Inebriety upon "Dipsomania and its Treatment by Suggestion." His main proposition was that some cases of inebriety could be cured by means of hypnotic suggestion. At the same time much depended upon the patient's willingness to be cured, his susceptibility to hypnotic influence, and the operator's handling of the case. The management of the patient was of importance, especially in the early stages of treatment, and it was desirable that some trustworthy attendant should always be at hand to assist in overcoming temptation. The actual suggestion made to the dipsomaniac when under the hypnotic influence was that alcohol was distasteful, and that he had lost all desire for its use. If the patient did not gain the power of controlling himself the treatment had failed in its object, inasmuch as self-control, and not artificial restraint, was its essential feature. From the lecturer's statements it is to be gathered that the cure has in some cases lasted over a period of several years, and if that be the case the medical profession will find a remedy of value in the treatment of dipsomania by hypnotic suggestion. At the same time, in view of former experiences, it is unlikely that the method will be generally accepted until its worth has been attested by further rigorous scrutiny and weighty attestation. The whole question is wrapped up in the tangled folds of physiological and pathological psychology, where all things are more or less nebulous. Coming from so shadowy a realm the practical physician may well be excused should he determine to apply the test of extended experience to this reintroduction of

hypnosis in inebriety, for the application is by no means novel. So far as one can gauge these mysteries the *cruz* of Dr. Bramwell's method is to restore and strengthen the individual will-power. Control has been lost in one particular direction, and he proposes to bring the remaining mental faculties of the sufferer into such a state that he can cause that control to be reinstated among the intellectual faculties. What is to bring about so profound and definite a change in the co-ordination of such abstract qualities? According to a recent writer, Dr. Ralph Vincent, hypnosis is a result of definite alteration in the nervous system, and it is as definite and physiological an alteration as that change produced by chloroform. After reading that statement it is natural to ask whether the results of hypnosis are likely to be more lasting than those of the anæsthetic mentioned. A patient recovers from chloroform narcosis, and his brain at once resumes the *status quo ante*. As a general rule a similar thing happens after mesmerism, or animal magnetism, or any of the other variously-named forms of hypnotism. In the case of inebriety Dr. Bramwell appears to think the effects of the hypnotic suggestion will be lasting. If so, he may be congratulated upon bringing into prominence a method of treatment that cannot fail to confer a vast benefit upon humanity. At the same time, it is only fair to point out that there are on record numerous instances in which excessive drinkers have, of their own free will, left off alcohol at once and for ever. Possibly he will say that in such cases control has been in abeyance and has not been lost, and that they are not in reality dipsomaniacs. The line of separation, however, is one of extreme tenuity. However, as practical men members of the medical profession will be glad to learn, if even here and there a dipsomaniac can be reduced to a state of automatic obedience sufficiently strong and lasting to cure his most distressing malady, the subject is certainly worthy of further investigation and report, and may well engage the future critical attention of the Society for the Study of Inebriety.

Notes on Current Topics.

What is Improvement in Consumption?

NOWADAYS it is the fashion for hospitals where modern methods of the treatment of phthisis have been adopted to report progress from time to time to their friends and supporters. As a general rule a large percentage of success is claimed, but the statement is deprived of value by the absence of any definition of what constitutes "improvement." It is likely that most consumptives drawn from the poorer classes would derive a temporary benefit from a stay in the wards of a wholesome and well-equipped hospital. Whether such a flickering in the socket, as it too often ultimately proves, justifies the swelling of hospital statistics of phthisis improved under treatment is another matter. From a statistical point of view it would be infinitely preferable if a standard definition

could be adopted generally in using the term "improvement." A reasonable demand would be that the patient fulfil certain conditions such as restoration to something like normal body weight, cessation of night-sweats, cough and hæmoptysis, a fairly normal balance of physiological functions. Above all, the improvement must be progressive, and not of the fleeting and ephemeral kind that there is reason to believe is accepted as the present basis of not a few favourable reports. In many ways the prevention of phthisis is one of the most attractive of the host of triumphs that await the advance of preventive medicine. It is all the more desirable that so noble a cause should not be hindered by the adoption of sensational or unscientific methods.

Medical Fees for Lunacy Certificates.

It is refreshing, because uncommon, to find a judge who takes such an accurate view of the rights and responsibilities of medical men in regard to the certifying of lunatics, and we are glad to give prominence to the finding of Judge Lushington in a recent case for this reason. Despite the fact that the Act seems to give discretion to guardians in this matter the judge found in favour of Dr. Hope, of Addlestone, who claimed seven guineas for certifying seven lunatics at the workhouse of the Chertsey district. His Honour, in giving judgment, said he had to decide what was a reasonable remuneration. The examination of such cases was one of great responsibility. The public interest and the fate of the patients was in the balance, and the responsibility attaching to the medical man was great. Dr. Hope seemed to have done his work thoroughly, and it did not matter whether it took him five minutes or 100 minutes. It was not a matter of time but of professional judgment and skill and experience. As we have said this is refreshing. The argument was adduced for the defence that as they were merely imbeciles they could be easily certified; but as Dr. Hope contended it is more difficult to get facts from imbeciles than from raving lunatics. It is to be regretted that a fight of this kind is not made oftener. The medical profession is less crowded than it was a few years ago. There is room "to live and let live," and therefore there should be "a combine" among medical men to resist the paltry fees of 5s. and 10s. often given to parish medical officers for medical certificates. Medical men do a great deal of gratuitous work in the way of granting certificates, and it seems that the more they do the more likely are they to be imposed on; but in the case of lunacy certificates the line against cheap remuneration should be sharply drawn, for these often involve considerable anxiety and risk and require careful safeguarding from possible actions.

ACCORDING to the *Westminster Gazette*, an order has been issued that medical officers joining the Navy will not be required to furnish themselves with sets of instruments and to keep them in repair, as this expense in future is to be defrayed by the Admiralty. Oddly enough, it will not come fully into operation before April 1, 1903.

Medical Student Statistics in France.

A FEW days since we commented upon the fact that the number of students entering upon a medical career is steadily decreasing, and according to *La Semaine Médicale* a similar diminution has been observed in France. The total number of students inscribed at the various medical faculties in France for the current year is thirty-nine less than for last year, and if we compare the totals since 1895 there is a deficit of 686, this deficit bearing as well on foreign as on native students. The diminution corresponds very closely with the progressive decrease in the number of students entering for the *officiat de santé*, this minor qualification being viewed with disfavour by the authorities. There are not wanting signs, observes our contemporary, that the medical career is held in less esteem now than formerly. So far, it is true, the number of persons who have obtained the degree of doctor of medicine has remained about the same, but, as the total comprises foreign students who, to the number of over 800, merely obtained the university degree which does not confer the right to practise on French territory, we may confidently look forward to a reduction under this head in the near future. Competition in France is not nearly as keen as in this country in the sense that the proportion of medical men per thousand of the population is inferior to that which obtains in this country and if this falling off is maintained the conditions of medical life may undergo marked modifications. One marked feature of medical practice in France is the reluctance of doctors of medicine to settle in the provinces outside the large towns, nor can this excite surprise in view of the very unremunerative nature of such practice compared with which country practice in this country is a dream of affluence.

The Royal Medical and Chirurgical Society.

IN spite of its enviable position of this, the only "royal" medical society, its management has been governed in the past by haughty traditions which have seriously militated against its popularity with the general practitioner and even with those who propose to follow the higher walks of the profession. Some past presidents have sought to infuse more of the social element into its management with, it must be admitted, somewhat disappointing results; but, if rumour is to be believed, the council are, after all, not as conservative as report would have it. We hear on good authority that some drastic changes are shortly to be inaugurated which cannot fail to enhance the prestige of the Society, and to extend its sphere of usefulness. One of the grievances of authors of papers in the past has been that they were deliberately subjected to an invidious selection in that no man could be sure that his paper would be judged worthy of subsequent publication in the "Transactions." The man in the street would imagine that if a paper were adjudged by the Council good enough to be read before the Society it must be good enough for publication in the official compilation. Certain it is that much heart-burning has been caused

at times by the exclusion of papers, on no very well-defined principles. We are pleased to hear that in future it is in contemplation to publish all contributions that have been brought before the Society. An even more startling innovation, and a welcome infraction of the short-sighted egotism which prompts the assertion of exclusive rights over accepted papers, is that in future authors will be allowed to publish their contributions in one or other of the medical periodicals. Unquestionably this step will do more than anything else to encourage men to devote time and energy to the elaboration of such contributions. The limited publicity ensured by reading a paper is aggravated by its being, at best "buried alive" in the "Transactions," and nothing could be better calculated to discourage authors who, or many of them, preferred in consequence to address themselves directly to the profession *via* the journals, with the result that it has become increasingly difficult to secure an adequate supply of subjects for discussion. We trust that rumour is true in this instance, and that in time to come the Royal Medical and Chirurgical Society will secure the preponderant position to which it is entitled.

King Winter at the War.

THE advent of the South African winter is making itself felt among our soldiers at the front. It is to be hoped that the War Office has realised the needs of the situation, and that plenty of blankets and wraps have been provided for bivouac purposes. To sleep out on the open veldt on a cold night clad in khaki is undesirable even when one has plenty of body covering, but when the latter is scanty the result is likely to be not less deadly than the Mauser bullets of the enemy. What a man wants under such circumstances is first of all a waterproof sheeting on which to lie. With a stout great coat and a blanket atop he is then fairly safe and will be able to sleep in spite of the cold. Unless some definite provision of this kind be made it is not unlikely that King Winter may play havoc with our troops. Cold acts in many ways both directly and indirectly. Thus it prevents sleep and acts as a depressant, two conditions that greatly weaken the resistance of the individual to the invasion of disease, and pith his value in the fighting ranks. Indeed, it may be said that a due amount of body warmth is absolutely necessary to any effectual display of courage and bravery in action. To maintain standard temperature conditions is clearly a far harder task in cold than in warm climates. Its chief essentials are food, exercise, and clothing. The food supplies seem to have been on the whole satisfactory, and there can be no question whatever as to an adequate amount of exercise. The only point remaining is that of clothing, under which term we include bedding and wraps. Should the unexpected duration of the war have disclosed any deficiency in that direction, it will doubtless soon be heard of in this country, despite the press censorship at the seat of war.

How to Feed up Army Candidates.

THE present war has disclosed not a few barren spots in our army administration, from which ground it is to be hoped future generations will reap abundant crops of applied wisdom under different methods of cultivation. One of these absurdities of the present system has been recently riddled through and through by a barrister, who has related this story of his rejection as a volunteer for service at the Cape. It appears he was a colonial roughrider before he came to England, a good shot, had a long volunteer experience, proved a good all-round athlete and scholar at college, and is now in the early prime of robust and perfect manhood. From these facts he would seem to be an ideal officer for service at the front. He was rejected, however, because he was under the regulation weight and did not measure enough round the chest. The sublime absurdity of the thing is clearly demonstrated by himself when he asserts that a fortnight's feeding up and athletics would remedy both the alleged defects. From his experience candidates for army examinations may gather one or two most invaluable hints. Let them keep a careful eye upon their weight and chest measurement as well as upon the cramming of catch-questions. Half an hour's extension and dumbbell exercise every morning will keep up the girth of the thorax, with a judicious course of Devonshire cream, patent foods, cod-liver oil emulsions, and a plentiful, rich, and varied dietary such as should delight the heart of the average keen schoolboy. Brains may or may not be on the programme, but heaviness is almost entirely a matter of feeding and food stuffs. As some satirist has said, "the army candidate may be clever, but he must be heavy." Herein lies hope for many a dull soul.

The Treatment of Gonorrhœa by Methylene Blue.

SPECIFICS for gonorrhœa are nearly as plentiful as anacæa for tuberculosis and meet with about an equal measure of success. This, however, would not justify a refusal to take cognisance of plausible suggestions for treatment, indeed the very futility of existing methods of treatment constitutes, on the contrary, a reason why we should be on the *qui vive* for useful suggestions. The latest departure is the use of methylene blue internally and as an injection. This aniline compound is reputed to exert a specific influence on the gonococcus, but it is also fatal to the various pyogenic bacteria of mixed infections. In an interesting article, embodying considerable personal experience with the drug, Dr. O'Neill, of New York, describes the method which he has found to answer best. He does not say much in favour of urethral injections of this agent which are inconvenient on account of its marked staining properties, but he advocates its internal administration in four one-grain doses daily. The formula which experience has shown to be safe and serviceable, is as follows: Methylene blue, 1 gr.; oil of nutmeg, 1 gtt.; oil of sandalwood, 2 gtt.; put up in gelatine capsules. It is claimed that by this method a cure may be effected within a

fortnight, or even less, but we are not in a position to affirm that equally good results will be obtained under different climatic conditions, for many of these rapid "cures" seem to fail when transplanted to our latitude.

Suprarenal Therapeutics.

In a recent number of the *New York Medical News* Dr. Bates publishes an interesting contribution to our knowledge of the therapeutical properties of suprarenal extract. By way of disarming criticism, he mentions that no untoward effect has ever followed the local or internal administration of the untainted gland, two pounds of fresh suprarenal capsule, in the form of an aqueous extract, having been swallowed without the production of any obvious ill-effects. When applied continuously to the healthy skin the effect is to whiten it, and if the epithelium be removed beforehand this effect is produced almost at once. Applied to an inflamed eye the redness forthwith disappears, and the conjunctiva becomes even paler than normal. This effect is only temporary, but tolerance is never induced, and it has no action on accommodation, nor does it exert anæsthetic properties. The extract, moreover, has an astringent action on other tissues than skin and mucous membrane, and its ingestion is followed by a reduction of the circulation in the various tissues and viscera. It is said to increase the tone of all muscular tissue, and it raises the blood pressure in virtue of its powerfully stimulating effect on the heart. Dr. Bates lays it down that in the aqueous extract of suprarenal capsule we have the most powerful astringent and hæmostatic yet known, which, in addition, possesses a really remarkable regulating and tonic effect on the cardiac muscle. Lastly, he recommends its use in congestive and inflammatory conditions of tissues and organs—a rather large order.

Intellectual Holidays.

MONOTONY is the bane of latter-day existence. Any man who is tied down to a sedentary or routine occupation must have a change now and then, or be prepared to fulfil the destiny of fate in a way that would almost certainly prove disastrous to his individual welfare. The truth of the general proposition thus laid down may be tested by a number of well-known facts. The average working man who has to labour from day to day at some dull mechanical round too often seeks diversion in an outbreak of wild debauchery. It is the same in the higher walks of life; men who live intellectual lives are compelled to seek variety from time to time in other spheres of activity. The busy barrister perchance goes Alpine climbing during the "long term," while the journalist does a month's fishing in Norway, and the merchant makes a tour in his yacht or spends his autumn leisure on the Yorkshire moors. "*Negus semper tendit arcum Apollo.*" The man who is continuously active with body or brains must follow the wise example of Apollo, or he will find his energies explode in the direction either of some uncontrollable impulse towards excess or of actual insanity. In dealing with

the mental side it is just as necessary to provide variety of scene and action as it is to furnish a mixed dietary in order to maintain a good physical standard. A sailor fed on turtle after a time contracts the greatest dislike to that rich food. So it is impossible for a man to thrive indefinitely upon an intellectual pabulum of French novels, or, for that matter, upon logical treatises or any other branch of scientific study.

Death from Tetanus.

FORTUNATELY deaths from lockjaw have become comparatively rare in this country. This immunity is doubtless due largely to the improved treatment of wounds, whereby access of the specified germs of tetanus is prevented. As everyone knows, this terrible symptomatic malady occurs as a secondary complication of wounds by a micro-organism whose normal habitat is in the earth. Hence most of the cases met with are those in which there has been a direct contamination of a surface lesion by the soil. In this way tetanus is sometimes set up by injuries contracted on the football field, or when a bare-footed child is cut on the foot by a sharp stone or a piece of broken crockery. An interesting case was reported last week from a London suburb. A lady between fifty and sixty years of age trod upon a nail projecting from a board in her conservatory. She was wearing thin slippers at the time and sustained a small punctured wound of the big toe. Tetanus developed soon afterwards, and she died from that cause. The house surgeon of one of the large metropolitan hospitals gave evidence at the inquest, and is reported to have stated that the nail had evidently been rusty and so caused blood poisoning. This chain of reasoning may have satisfied the conscience of a newspaper reporter, but can hardly represent the scientific opinion of even the youngest of house surgeons. The relation of oxide of iron to blood-poisoning has not yet found a place in the text-books. The specific action of the tetanus bacillus, however, when introduced by inoculation upon a nail, whether rusty or not, is another matter.

Brain Syphilis.

THE importance of a knowledge of the main features of syphilis is of considerable importance to all medical practitioners. In dealing with arterial as apart from meningitic syphilis, there is a period during which there are functional disturbances connected with changes that it is still within the power of curative medicine to remedy. The motor troubles usually take the form of a hemiplegia or more commonly of a monoplegia. The intellectual symptoms are depression, general progressive enfeeblement, and all kinds of aphasia, especially motor aphasia. Obliterating arteritis causes ischæmia of the brain, which is often little evident until some extra strain induces paralysis, aphasia, or an epileptiform attack. Arterial syphilis is sharply marked off from the meningitic or gummatous form by the absence of irritative phenomena. The meningial class is divided into gummatous

infiltration, miliary gummata, and inflammatory meningitis. The motor symptoms of the meningeal variety are chiefly epileptiform and spasmodic attacks. Among sensory troubles are headache, severe and worse at night; while the affected part is tender on percussion. Special senses are often involved. Aphasia is uncommon, but delirium and hallucinations are frequent. Intelligence is rarely affected. From these statements it will be clear that it is within the power of any well educated practitioner of medicine to make himself acquainted with the main facts of cerebral syphilis. Details may safely be left to the untiring energies of the nerve specialists.

Disease in the Army.

It is a familiar experience of campaigns that disease kills more soldiers than the steel and shot of the enemy. That fact has been brought home to us once more by the painful vicissitudes which our troops have had to sustain in the present South African war. The mortality from dysentery and enteric fever has been simply appalling, and when the right time comes an inquiry is imperative into the methods adopted by the Army Medical Department to prevent the ravages of preventible disease. Before the war it was notorious that South Africa, away from its southern centres of population, was, so to speak, saturated with the germs of enteric fever. That being so, one would expect an intelligent Medical Department to insist upon the provision of a full supply of pocket filters for use in the field, and for the systematic sterilising of drinking water. Another disastrous but less avoidable malady that has lately invaded our camps is influenza. An interesting illustration of the relative mortality due to germs and to weapons is afforded by the recently published statistics of the siege of Ladysmith. During the four months in which the gallant little city was beleaguered by the Boers the actual oss in killed among officers and men amounted to 322 whereas no less than 563 died of disease. The number of wounded is returned as 559, but the figures given show that a large proportion of the force was disabled by disease. There were 393 deaths and 1,766 admissions from enteric fever; 117 deaths and 1,857 admissions from dysentery; 59 deaths and 524 admissions from wounds, and 31 deaths and 6,451 admissions from other causes. Decidedly it is safer to be wounded nowadays in modern warfare than to take a camp disease.

Self-Constituted Consultants.

We apprehend that our correspondent "Free-Trade," who criticised in our issue of April 4th our observations on this subject, confounds the ordinary general practitioner with the expert consultant. The ordinary club doctor or dispensary hack may be called a consultant, as his advice is asked for every petty ailment, and his fees need not be more than those of his co-practitioners. But the physician or surgeon who is engaged and salaried by the Birmingham committee to act as consultant, is supposed to occupy a different role. His function

is to supervise, as an expert, the treatment of the general practitioner, and our contention is that a young practitioner of four years' standing cannot be supposed to be an expert Consultant, and that, if he has had the requisite experience for that rôle, he would be very unlikely to sell his time and his mature advice for half a sovereign—*ergo*, that these Birmingham gentlemen, though they may be excellent general practitioners, are not consultants in the ordinary acceptation of the term.

The Marriage of Unhealthy Persons.

WITH the readiness to adopt pseudo-hygienic fads which is characteristic of neo-democracies, the legislature of Colorado has decreed that persons will not be allowed to join in holy, or any other, matrimony unless they can satisfy a medical board that they are free from tuberculosis, syphilis, and sundry other morbid conditions which the Colorado legislators regard as impediments to marriage. This is a large order, and public opinion in that distant territory must be greatly in advance of that in the Old World if it endorses so drastic an interference with the liberty of the citizen in matters matrimonial. That it is not universally approved may be inferred from a letter which appeared in a recent number of the *New York Medical News*, signed by Dr. Fuchs, who protests energetically against the policy of these coercive-philanthropy advocates who, he urges, "are building up a despotism of democracy certain to become as hateful as the despotism of autocracy."

A Feat of Deglutition and its Consequences.

THE *New York Medical Record* tells an instructive story of a certain mountebank who gained a precarious livelihood by swallowing, or pretending to swallow, articles and things which are not generally regarded as "edibles." As a matter of fact, his skill consisted in dissimulating the pointed fragments of glass and hardware in his sleeve while he went through the act of deglutition. One day, however, a distrustful audience obliged him to take off his coat, whereupon he actually introduced the lot into his stomach, with the result that he had a bad attack of indigestion, which was only relieved by gastro-tomy.

Female Nurses at the Front.

SURGEON-GENERAL JAMESON is of the opinion that female nurses at the front are out of place and undesirable, and mainly because they would interfere with the mobility of a field hospital. He affirms that a field hospital to be of any use must be perfectly mobile, and that this would be impossible with female nurses. We must confess to feeling some difficulty in comprehending how this would be the case. Female nurses, we doubt not, are quite capable of adapting themselves to circumstances, and the probability is that the exigencies of active service with a field hospital would not prove a stumbling block to their employment. Taking a broad view of the matter we should be disposed to think that if

women were prepared to isolate themselves from their sex among many thousands of men, they would make no difficulty in meeting every requirement which active service demanded of them.

The Royal City of Dublin Hospital

THE Queen, in authorising the Princess Christian to announce that the prefix "Royal" should be added to the title of the institution, conferred a special honour upon the hospital and its staff, and distinguished the occasion of the laying of the first stone of the nurses' wing. It may not be generally known that the institution was founded nearly sixty years ago by a number of the most distinguished physicians and surgeons, including Arthur Jacob, Charles Benson, William Hargrave, Thomas Edward Beatty, John Hatch Power, and James Apjohn. They contributed the necessary funds for the purpose, and Jacob, as representing them, took a lease from the Incorporated Society of the building, which the hospital still occupies. On the occasion of the laying of this foundation stone the chairman of the Board of Governors naturally took precedence in presenting the address to the Princess, and was seconded by Mr. Croly, Senior Surgeon to the Hospital and Senior of the Board. Subsequently the Princess was pleased to request that the Croly female ward should be henceforth named the Helena ward. The proceedings went off with great *éclat*.

The Role of the Gonococcus as the Cause of Gonorrhœa.

NEISSER has already expressed his belief that the gonococcus may infect the mucous membrane of the vagina without causing the clinical signs of gonorrhœa. In view of this statement some investigations have been carried out by Schiller. He examined three hundred women consecutively, and in thirty-seven only of these was he able to detect the presence of the gonococcus in the vagina. Among the latter, also, were signs of gonorrhœa, such as urethritis, vaginitis, vulvitis, metritis, and so forth. On the other hand no lesion whatever was present in the genito-urinary organs of the remainder of the 300 patients, in whom no gonococcus was found. Schiller, therefore, is disposed to question the correctness of Neisser's view respecting the gonococcus and its non-liability to cause gonorrhœa.

Registered Monopolies.

THE Plumbers Registration Bill, to which we have often referred as an object lesson of what the profession has to expect when the midwives, the spectacle sellers, and *hoc genus omne* come to demand monopolies, has been dropped as a legislative proposal. Mr. Lee Knowles, M.P., who has championed the measure in the House has substituted for it a resolution declaratory of its principle. Abstract pronouncements on such a subject seldom get a chance of being discussed, still less of adoption, and if adopted, they have no validity until a Bill is passed through all its stages in both Houses. Let us hope that a last adieu may, therefore, be paid to this latest attempt to establish a new trade monopoly.

Candy for the Soldiers.

FIFTY tons of sugar candy have been dispatched to the troops engaged in subjugating the Philippines, on the advice of the medical officers who hold that in the tropics a moderate consumption of confectionery promotes health and satisfies a not unhealthful craving of the stomach. We offer this assumption for what it is worth to those benevolent persons who are occupying themselves with the provision of "comforts" for our soldiers who are engaged in the arduous task of conquering the South African Republics.

A Tuberculosis Cure.

AMERICA is a great country for "cures." The last is the Crotle cure for tuberculosis. It was given a three months trial in a well-known hospital in New York, and the result, anticipated with much interest was *nil*. It was found to be absolutely valueless. So the American medical practitioners and the members of the American Medical Association have decided to have nothing further to do with this new cure. Thus the experience of the Keeley cure has been repeated, but on a much smaller scale.

A Twin-Bearing Family.

THE New York *Medical Times* gives some interesting details concerning the fertility of the female members of a certain family. Three sisters living in the same village gave birth on the same day to six children, three sets of twins, two pairs being boys and one girls. This occurrence tends to show that the incidence of multiple births concerns the mother rather than the putative father.

PERSONAL.

H.R.H. THE PRINCESS BEATRICE has consented to lay the foundation stone of the new Belgrave Hospital for Children at Clapham, at the end of June.

PROFESSOR "TOM" JONES, of Manchester, together with a number of his medical colleagues, left last week to take charge of the Welsh Hospital at the front.

HER MAJESTY THE QUEEN sent a message of sympathy to Lady Priestley last week immediately on hearing of the death of her husband, Sir William Priestley, M.P.

MR. FREDERICK TREVES, F.R.C.S., landed at Southampton from South Africa on Saturday, having returned to England on board the *Dunvegan*, with Sir George White, the hero of Ladysmith.

PROBATE of the estate of Dr. F. C. Turner, late physician to the London Hospital, has been entered at the sum of £55,083, by his brother and acting executor, the Right Rev. C. H. Turner, Bishop of Islington.

SIR JAMES CRICHTON BROWNE, M.D., F.R.S., has been requested to allow himself to be put in nomination for the Parliamentary representation of Edinburgh and St. Andrew's Universities, in succession to the late Sir Wm. Priestley, M.D., M.P. Unfortunately Sir James has been compelled to decline the honour.

SURGEON-MAJOR-GENERAL WILLIAM ROE HOOPER,

C.S.I. (I.M.S. Bengal), and Dr. Frederick Page (Surgeon to the Royal Infirmary, Newcastle-on-Tyne), have been elected Fellows of the Royal College of Surgeons, England, under Section 5 of the Charter of the 15 Victoria, relating to members of 20 years' standing.

THE Jacksonian prize of the Royal College of Surgeons, England, for the year 1899 has been awarded to Mr. Harry Lambert Lack, F.R.C.S. Eng., of King's College Hospital for his dissertation on the pathology, diagnosis, and treatment of inflammatory affections of the nasal fossæ and associated sinuses and air cells.

Mrs. GANT, wife of Mr. Frederick Gant, F.R.C.S., consulting surgeon to the Royal Free Hospital, has by her will bequeathed an unusual legacy to two medical societies, viz., the Medical Society of London and the Royal Medico-Chirurgical Society, each of which receive £100. Mrs. Gant's estate has been valued at £15,510.

THE committee entrusted with the erection of a memorial to the late Mr. O'Grady, Surgeon to Mercer's Hospital, Dublin, has, when winding up the movement issued to the subscribers an excellent photograph of the deceased gentleman and a neatly printed record of his services to the profession and the public in Ireland. The universal respect with which Mr. O'Grady was regarded by his professional brethren will ensure their affectionate remembrance.

THE death was announced last week of Mr. Downes, immediate past president of the Pharmaceutical Society of Ireland. He carried on business as Brooks and Co., in Dublin, and during his term of office as president he threw his whole energy into his duties, until he fell into the ill-health which eventuated in his death. He met with a severe street accident about a year ago, from which his recovery was only partial, and he felt obliged to resign his presidential office a few weeks since.

WE regret to have to announce the serious illness of Dr. Hunter McGuire, of Virginia. On the 19th ult. whilst going to his private hospital, St. Luke's, Richmond, he was stricken down, from a cerebral embolism in the left hemisphere of the brain. He was immediately brought to his private residence, where he was found to be suffering from right hemiplegia, with loss of voice and power of deglutition. We hope that the next mail may tell of an improvement in the health of this great surgeon, who is not more remarkable for his surgical skill than for his generous and honest heart.

THE MIDWIVES BILL.

This Bill, although its ordinary good luck followed it, failed to get into the Report stage on April 6th, for which date it was in the House of Commons' notice paper, and its further progress is now postponed until June 27th, after which time the utmost vigilance of the opponents will have to be exercised, as no doubt it will be tabled for discussion at frequent periods thereafter. On the 6th inst. it was afforded a special chance by the unexpected collapse of the discussion on the South African question, but a dreary debate on a Scotch Bill which came before it so depleted the House of members that a count was easily carried and the Bill shelved for the present. The profession has therefore nearly ten weeks to repair the damages sustained by their sel-

confidence and unpreparedness, and we have every hope that when June 27th comes round no more will be heard of the measure, at least for this Session.

THE MIDWIVES BILL.—DR. GLOVER'S REPLY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Will you kindly publish the following letter in reply to the resolution passed at the meeting in Cannon Street Hotel, and referred to in your issue of April 11th.

Yours very truly,

J. G. GLOVER.

"23, Highbury Place,

"April 12th, 1900.

"GENTLEMEN,—I have received from you a letter conveying the following resolution, moved by Dr. Lorimar Hart, and seconded by Mr. Joseph Smith, at a meeting presided over by Mr. George Brown, and in its later and attenuated stage by Dr. Toogood:—

"That whereas the General Medical Council and others who support the registration of midwives in the mistaken expectation of 'influencing important details' have signally failed to amend the worst provisions of the Bill before Parliament, it is time that honestly mistaken supporters of such registration should cease to trifle with a public danger, and in view of the plebescite recently taken by the *Lancet* indicating the sense of a great proportion of his electors, this meeting regretting Dr. Glover's attitude of indifference to these considerations, invites him by resigning his seat and seeking re-election to afford to his constituents a just opportunity of re-considering their relations to him."

It is pleasant to have the assurance conveyed in your covering letter that no personal unfriendliness is meant by such a resolution. I accept the assurance, though it is very difficult to construe the procedure of the gentlemen concerned in this matter as either reasonable or courteous. The impression produced on others affected by your views and methods may, perhaps, be gathered from the fact that two only were present of a large number of Members of Parliament whom you invited to attend, and that the great profession to which we belong was in the end, with its 23,000 members, represented by seventeen persons, who thought it seemly to ask a direct representative to resign because of a disagreement with him as to the best way of dealing with the question of midwives.

"I am sure nothing would more effectually surprise you, or lower me in the esteem of the great body of the profession, than that I should take such a resolution seriously. I shall only remind my constituents generally that as a matter of fact my vote in the *Lancet* ballot was given against this Bill, and will still be given so until I am satisfied that the midwives to be licenced shall be recognised in all unusual cases to appeal for help to the medical profession.

"It is only fair to the Medical Council to say that it has in most important ways influenced the details of this Bill. Even as the Bill stands at present, the Council has secured a control over licensed midwives which would probably not have been conceded if Parliament had thought that the profession was represented by the seventeen modest gentlemen who asked me to resign a trust which was given me for the third time by thousands of practitioners, on the explicit understanding that I would support such legislation on conditions.

"Believe me, Gentlemen, yours very truly,

"J. G. GLOVER.

"F. S. Toogood, Esq., M.D. Lond.

"John P. Harvy, Esq., M.D. Dub."

THE EXTENSION OF THE MIDWIVES BILL TO IRELAND.

The following communication has been addressed by the Council of the Irish Medical Association to the Irish Members of Parliament and the members of the Grand Committee on Law:—

THE MIDWIVES BILL.

SIR,—I am directed by the President and Council of the Irish Medical Association to ask your special attention to the terms of this Bill, which has passed second

reading in the House of Commons, has gone through the Grand Committee, and now stands for the Report stage, which will probably be taken immediately after the recess. This Association has not heretofore taken special notice of this Bill because it was not proposed to extend it to Ireland, but, inasmuch as it has been recently suggested that it should be amended so as to do so, the President and Council feel compelled to intervene for the purpose of most earnestly requesting you to resist, by every proper means, such extension.

They submit that there is little in common between the midwifery systems of England and Ireland. In England there is a large population of women who call themselves midwives, but who have never received any education or qualification whatever in midwifery, yet they practise widely amongst the lower commercial and artisan classes. In Ireland there may be said to be no such class, inasmuch as the lower commercial people and artisans, as well as the peasantry, are attended gratuitously by the Dispensary Medical Officer or by the qualified midwife duly appointed and paid by the Guardians. In Ireland no speciality in medicine or surgery is better looked after by the authorities and the medical officers than midwifery, and it may be said with truth that the Irish system needs neither registration nor any other arrangement to make it as nearly as possible perfect, and that there is no demand whatever for a new order of midwives. Moreover, Ireland is proud to believe that its system of instruction in midwifery by the Rotunda and Coombe Lying-in Hospitals is acknowledged by all to be greatly superior to that afforded to the English midwifery students, and the President and Council submit that it would be a grievous injustice to Ireland if, as is proposed, a host of women, indifferently or not at all educated, were admitted to competition with midwives diplomated by the Irish training and examining bodies.

To justify the Association in urging you to oppose the extension of this Bill to Ireland, it is necessary to explain that it proposes to confer the status of official registration and right of practice upon the following classes:—

(a) An unlimited number, probably several thousands, of so-called midwives now practising without qualification, on production of "satisfactory evidence" . . . that they have been "at the passing of this Act in *bona fide* practice as" midwives. The "satisfactory evidence" in the case of registered dentists and others was a simple declaration by themselves of themselves that they were so practising.

(b) A further contingent, to the number of over 4,000, of midwifery nurses who have received certificates from the Obstetrical Society of London and other cognate institutions.

(c) For the future, all women who may be licensed by a County Council, the conditions of licensing being prescribed by a central Midwives Board. . . .

This Bill purports to impose restrictions upon the wholesale practice of midwifery and upon the collateral practice of contingent diseases by the midwife, but experience proves that such paper restrictions will prove to be wholly illusory. These women, once admitted to practice and certified by Government authority, will practise anything which is likely to prove lucrative, inasmuch as no penalty is imposed by the Bill for breach of the nominal restrictions, and thus the physicians and surgeons in Ireland may be subjected to the competition of a crowd of ignorant women. For these reasons the President and Council urge you to resist the extension of this Bill to our country.

We apprehend that the circular letter issued by the Royal College of Physicians in Ireland on this subject was written under the misconception that, if the Bill is not extended to Ireland, the midwives certified by that College and by the Rotunda and Coombe Hospitals would be debarred from practice, as such, in England, Wales, and Scotland. The terms of the Bill do not seem to us to warrant such an apprehension. The third clause says:—

"Any woman who, within two years of the date of this

Act coming into operation, claims to be certified under this Act, shall be so certified provided that she holds a certificate in midwifery from the Royal College of Physicians in Ireland or from the Obstetrical Society of London, or such other certificate as may be approved by the Central Midwives Board or produces evidence satisfactory to the Board that, at the passing of this Act, she has been in *bona fide* practice as a midwife and that she bears a good character."

This clause, we think, amply protects the registration rights not only of the Bodies which are so alarmed, but of all Irish certified midwives; and, therefore, see no sufficient cause for asking that the Bill shall be extended to Ireland.

Scotland.

[FROM OUR OWN CORRESPONDENT.]

ANNUAL REPORT OF THE MEDICAL OFFICER OF HEALTH OF THE CITY OF EDINBURGH FOR 1899.—This annual report, the second of the series, if we remember aright, in its present comprehensive form, is a monument of industry, and an example how to do things of this nature. As a rule annual reports of this official species linger long in the gestation stage, and the actual printing of them resembles in its turn the delays of a protracted "second stage." An annual report running to 72 pages, and including four well executed graphic charts, and twenty-one tables, more or less lengthy—one extending over 24 pages—full of valuable details, and affording almost all that may be of interest in connection with the public health of the city for the preceding twelve months, is seldom so quickly delivered. One point brought out is characterised as being very satisfactory, the fact that a larger and larger percentage of cases of notifiable zymotic diseases are sent to the City Fever Hospital each year for treatment. Thus in 1890 only 29.59 per cent. of the diphtheria cases notified were admitted, 48.02 per cent. of the typhoid, 40.10 per cent. of the scarlet fever cases; in 1899 48.74 per cent., 71.62 per cent., and 68.86 per cent. respectively were treated in the hospital. The advantages of hospital treatment are shown by the mortality notes among notified cases of zymotic diseases treated at home, and of those admitted, although the latter comprised a larger proportion of severe cases. In individual diseases the death-rate of 3.86 per cent. in scarlet fever cases compares with one of 6.62 per cent. outside; in typhoid fever, 12.96 per cent. with 15 per cent.; diphtheria, 7.48 per cent. with 12.88 per cent. Only in measles was the inside rate over that without, 2.27 per cent. and 1.9 per cent.; accounted for by the admission of cases of measles only when there is sufficient accommodation, and even then only in the severer cases. It would be of value and interest if the immediate causes of death in the fatal cases of measles treated in the hospital were classified, and still more so if they could be contrasted with similar data obtained from outside. Probably measles is not so suited for hospital treatment as the other zymotics, and intercurrent broncho-pneumonic attacks more readily, induced by the presence of an agent which co-operates with the cause of measles in producing them. Although the total number of diphtheria cases reported and treated in 1899 is higher than for the three preceding years, the death-rate per cent., which averaged from 1895 to 1897 20.6, falling in 1898 to 14.12, only equalled 10.03, a result ascribed to the effects of antitoxin treatment, the more so in that the hospital figure of 7.48, given above, contrasts so favourably with the outside 12.88 per cent.; as the patients of the first class were presumably more often subjected to its benefits. Interesting accounts of four outbreaks, three of scarlet fever and one of typhoid, in connection with the possible source of infection through the agency of the milk supply to the persons attacked are included, and the sequence of events clearly given. In each, however, an element of doubt is present, and the verdict upon them must remain the Scotch one of "not proven" though suspected.

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

ELECTRIC HEAT BATHS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your issue of April the 11th appears the condensed report of a paper read by Dr. Godfrey Carter at the Sheffield Medico-Chirurgical Society on "Electric Heat and Light Baths."

The principle of applying extremely high temperatures, from 250° F. to 300° F. or even 400° F. to the human body was described therein, and two systems were mentioned, the "Greville" and the "Dowsing." Now, Sir, anyone acquainted with this subject knows that the application of hot dry air at the temperature mentioned was due to Mr. L. A. Tallerman, who introduced the method some eight or nine years ago. Other systems are simply imitations and modifications of his plan, but in all the central therapeutic factor is extreme heat. In each instance, I believe, the apparatus has been made the subject of a patent.

It seems a little unfair, then, that medical men should read articles on hot-air treatment in which Mr. Tallerman's system is ignored, whilst those of unblushing imitators are freely quoted. Such a state of things is hardly consonant with the traditions of an honourable profession, and in the article above quoted has doubtless arisen from a want of acquaintance with the facts of the origin of the treatment, the credit for which clearly rests with Mr. Tallerman.

I am, Sir, yours truly,
D. WALSH.

Bentinck Street, Cavendish Square, W.

WORKHOUSE MEDICAL OFFICERS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Kindly allow me to call the attention of the physicians to Union hospitals to the fact that the law gives them the right to insist on increased remuneration for the increased duties which the new system of account keeping, introduced in consequence of the Local Government Act, imposes on them. From communications I have received from other workhouse Medical Officers, I do not think I exaggerate when I say that these clerical duties are at once onerous and distasteful to a degree. Professional men always find clerical work disagreeable to them and calculated (as in the Army Medical Service for example) to take them away from their proper business. In the present case the law is plainly on our side, and it should be, through no fault of ours, that we do not get the full benefit of it, especially when we recall the fact that while another branch of the service has secured a free month each year we have been left out in the cold. I would be glad to hear from some of the workhouse men.

The Local Government Board have given so much as a hundred a year additional to Union clerks, and though we cannot expect as much as that, we might as well leave the appraisalment to the Local Government Board, and I believe such is the law.

I am, Sir, yours truly,
THOMAS LAFFAN.

Cashel, April 11th, 1900.

Obituary.

MR. GLASGOW PATTESON, OF THE MEATH HOSPITAL, DUBLIN.

As this gentleman had been on previous occasions and recently in very failing health, the announcement of his untimely death last week at the residence of his family in Dundalk did not come as a surprise. Although scarcely forty years of age he had attained high character both as a surgeon and a biologist. He took his first professional qualification in 1885, having immediately won the Surgical Travelling Prize of the University of

Dublin, which enabled him to continue his studies in London, Berlin, and Vienna. He became a Fellow of the College of Surgeons in 1890, and since then has served as examiner in that college. His contributions to the literature of the profession were numerous, and valuable.

Royal College of Surgeons in Ireland: Election of Examiners.

A MEETING of the college will be held on Tuesday, May 1st, to elect the following examiners:—Two examiners in anatomy, two in surgery, two in physiology and histology, one in biology, two in ophthalmology, one in pathology and bacteriology, one in pathology, one in midwifery and gynecology, one in sanitary law and vital statistics, one in engineering and architecture, one in chemistry and physics, one in chemistry and physics (dental court), two in dental surgery and pathology, two in mechanical dentistry, one in languages, one in mathematics, physics, dictation, and English essay. "Graduates of any university which may be from time to time recognised by the college shall be eligible for election as examiners in the subjects of general education. All the other examiners shall be Fellows or Licentiates of the college."

A shabby Defence.

DR. CAMPBELL MCCOLL, of Cardiff, had to sue one of his patients for his fees in respect of an attendance on a child suffering from diphtheria. The defence was that he had shown negligence in the treatment in that he had advised home treatment instead of sending the child to the hospital and, moreover, that he had improperly removed the tracheotomy tube and had replaced it with the aid of a penknife. The Judge sharply called the solicitor for the defence to account for making himself the mouthpiece of allegations which he was not prepared to endorse, and roundly declared that he was not going to allow a medical man's reputation to be attacked when he sued for his fees, adding that he had the greatest possible objection to "these baseless, improper and dishonest insinuations. He ultimately gave judgment for the plaintiff with costs. Truly a Daniel has come to judgment."

Society for Relief of Widows and Orphans of Medical Men.

A QUARTERLY court of the directors of the Society was held on Wednesday last, April 11th, Dr. Church, treasurer, in the chair. Three new members were elected and the deaths of six reported. Applications for grants were read from 48 widows, eight orphans, and six recipients from the Copeland Fund, and it was resolved to distribute £1,173 10s. among them at the next court. A first application for a grant was made from a widow, and a grant at the rate of £50 per annum was given her. A special grant of 50 guineas was made to a widow under Bye-law 70. Grants were made to two orphans of £25 each towards their self-maintenance. The report of 1899 was read. The following gentlemen were nominated for election at the annual general meeting to fill the vacancies among the officers of the Society:—President: Mr. Christopher Heath; Vice-Presidents: Mr. W. H. Bennett and Mr. Manby Sims; Directors: Dr. Borlase Hicks, Mr. Simmonds, Mr. L. Read, Mr. Willis, Mr. Milburn, Dr. Buzzard, and Dr. Morison. It was decided to hold the annual general meeting on Wednesday, May 30th, at 5 p.m.

PASS LISTS.

The Irish Conjoint Examination.

FIRST PROFESSIONAL EXAMINATION:—PASSED.

- (a) Passed in all Subjects.—1. Honours in Order of Merit: Miss J. C. Hargrave, M. Lockrine, P. Maher. 2. Pass Alphabetically: T. C. Leslie, K. P. Neavy, J. Parke, J. Quirke.
(b) Completed Examination: J. M. J. Carolan, T. C. Fitzgerald, L. Kelly, J. Kelly, P. Kinsella, J. J. A. McKenna, E. E. J. Sheridan, L. F. Stokes.
(c) Anatomy: J. M. G. Foley, W. F. B. Loughnan, D. de C. O'Grady.
(d) Biology: C. J. R. Clarke, W. J. Delaney, J. M. G. Foley, W. F. B. Loughnan, T. Moran, E. C. Macdermott, V. H. MacSwiney, C. F. Shaw.
(e) Chemistry and Physics: W. J. Delaney, J. M. Moriarty, S. C. Macdermott, D. de C. O'Grady.
(f) Pharmacy: W. S. Carter, W. J. R. Clarke, W. B. F. Loughnan, E. C. Macdermott, C. F. Shaw.

Notices to Correspondents, Short Letters, &c.

✉ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a distinctive signature or initials, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

ODDIES.—We cannot recommend individual specialists. Any advice you may require on this point can readily be obtained from your usual medical man.

CREMATION IN IRELAND.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR.—1. Can a person make a will, with a provision in it that his body be cremated after his death, after having the cause of death certified by two independent medical practitioners and a post-mortem made?

2. Can cremation be carried out in Ireland—there are no crematoria available, but if a person desires cremation after death in Ireland, could he leave instructions that his body after death be cremated in say an enormous wood fire?

3. Who is the proper person to apply to should there be any technical or legal barriers to this method of disposal in Ireland?

NITROGEN.

1. Yes. 2. No. A crematory is essential. Application for a licence to erect one should be made to the Local Government Board. The cost ranges from £1000 upwards. Funeral pyres require very dry, inflammable wood, quick burning oils, and aromatic balsams; these latter are necessary to overcome the noxious smell of the gases first given off by the body. 3. The chief secretary to the Lord Lieutenant. Crematoria have been erected at Woking, Manchester, Glasgow, Liverpool, and Hull. A letter to the hon. secretary of the Cremation Society, J. C. Swinburne Hanham, 324, Regent Street, London, would, no doubt, get such further information as our correspondent may require.—ED.

Meetings of the Societies and Lectures.

WEDNESDAY, APRIL 18TH.

ROYAL MICROSCOPICAL SOCIETY (20, Hanover Square, W.).—8 p.m. Mr. W. Carruthers (President): Demonstration on the Structure of some Palaeozoic Plants (with sections of the plants thrown on the screen).

NORTHERN AND MIDLAND DIVISION OF THE MEDICO-PSYCHOLOGICAL ASSOCIATION (County Asylum, Whittingham, near Preston, Lancashire).—Business Meeting. 4 p.m. Discussion on the New Lunacy Bill (Dr. Mould). Papers by Mr. F. O. Simpson and Catherine M. Blackwood, L.R.C.P. Edin.

THURSDAY, APRIL 19TH.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road).—8.30 p.m. Clinical Evening.

FRIDAY, APRIL 20TH.

EPIDEMIOLOGICAL SOCIETY OF LONDON (11, Chandos Street, Cavendish Square, W.).—7.45. Council Meeting. 8.30 p.m. Ordinary Meeting.

Appointments.

BEATSON, G. T., M.D. Edin., C.M., L.R.C.S., has been appointed Visiting Surgeon, Western Infirmary, Glasgow.

BIENEMANN, A. J., M.B., C.M. Edin., Medical Officer for the Farnham Royal District, Eton Union.

BOWLES, BEATRICE, M.B., C.M. Lond., Assistant Medical Officer for the Workhouse of St. Matthew, Bethnal Green, London.

BROWN, W., M.D., C.M. Glasg., District Medical Officer by the Bristol Board of Guardians.

BUCHANAN, G., M.D. St. And., L.R.C.S. Ed., F.F.P.S. Glasg., Honorary Consulting Surgeon, Western Infirmary, Glasgow.

COOK, H., M.B., C.M. Aberd., District Medical Officer by the Bristol Board of Guardians.

FALCONER, H. B. L.S.A. Lond., District Medical Officer by the Bristol Board of Guardians.

FLOOD, P., L.R.C.P., L.R.C.S. Irel., District Medical Officer by the Bristol Board of Guardians.

FORREST, J. S., L.R.C.P. Edin., L.F.P.S. Glasg., Medical Officer for the Sanitary District of Walkwork, Alnwick Union.

FOSTER, M. B., L.R.C.P. Lond., M.R.C.S., D.P.H., Medical Officer for the First Sanitary District, Ware Union.

GENT, W. (J.), L.R.C.P., L.R.C.S. Edin., District Medical Officer by the Bristol Board of Guardians.

HAWKINS, W. R. T., M.R.C.S., L.R.C.P. Edin., District Medical Officer by the Bristol Board of Guardians.

HAY, GEORGE G., M.B., Ch.B. Edin., House Surgeon and Dispenser to the Northern Infirmary, Inverness.

JONES, J., L.R.C.P. Edin., L.F.P.S. Glasg., Medical Officer for the Dolgelly Sanitary District of the Dolgelly Union.

MARTIN, J. M., M.B., B.C. Cantab., D.P.H., Medical Officer for the Rural Sanitary District by the Stroud Rural District Council.

MASON, G. B., L.R.C.P. Lond., M.R.C.S., Medical Officer for the Sixth Sanitary District, Lutterworth Union.

McKENZIE, W. M.A., M.B., C.M. Aberd., District Medical Officer by the Bristol Board of Guardians.

MORGAN, A. T., M.D. Brux., L.S.A. Lond., District Medical Officer by the Bristol Board of Guardians.

MUIR, J. C., M.B., B.C. Camb., L.R.C.P. Lond., M.R.C.S., Senior Assistant Medical Officer for the Crumpsall Workhouse, Manchester.

PAGE, G. S., L.R.C.P., L.R.C.S. Edin., District Medical Officer by the Bristol Board of Guardians.

SEDDON, A., L.R.C.P., L.R.C.S. Edin., L.F.P.S. Glasg., Medical Officer for the Frome Sanitary District of the Frome Union.

SHEPPARD, E. J., L.R.C.P., L.R.C.S., District Medical Officer by the Bristol Board of Guardians.

SISSONS, A. T., M.B., Ch. Vict., Second Resident Assistant Medical Officer for the Crumpsall Workhouse, Manchester.

SMITH, F. J., M.D. Oxon., F.R.C.S., Physician to the National Orthopaedic Hospital, Great Portland Street, London.

STAPLE, J. DIBLE, M.R.C.S., L.S.A., District Medical Officer by the Bristol Board of Guardians.

WARNER, E. H., M.D., C.M. Edin., District Medical Officer by the Bristol Board of Guardians.

WIGG, J., L.R.C.P. Lond., Medical Officer for the Second District, Parish of St. Pancras, London.

Vacancies.

Bolton Infirmary and Dispensary.—Junior House Surgeon. Salary £80 per annum, with apartments, board and attendance.

County Asylum, Shrewsbury.—Junior Assistant Medical Officer. Salary to commence at £130 per annum, rising £10 a year to £150, with board, lodging, and washing. No liquors provided.

County Borough of West Ham Lunatic Asylum.—Superintendent. Asylum now in course of erection at Chadwell Heath, Essex.

Salary £600 per annum, with unfurnished house, light, washing, and garden produce. Apply to the Town Clerk, Town Hall, West Ham, E.

Cumberland and Westmorland Asylum, Garlands, Carlisle.—Junior Assistant Medical Officer, unmarried. Salary £100 a year, with board and residence.

Drumcondra Hospital.—Honorary Assistant Physician; also two Anaesthetists. Applications to the Registrar. (See advt.)

Hospital and Dispensary, Newark-upon-Trent.—House Surgeon, unmarried. Salary £80 per annum, with board and lodging in the hospital.

Kidderminster Infirmary and Children's Hospital.—House Surgeon, unmarried. Salary commencing at £140, increasing annually by £10 to £170, with rooms in the Infirmary and attendance.

Option of board at £40 per annum.

Lincoln Union.—Medical Officer for the Workhouse at Lincoln. Salary £70 per annum, with certain perquisites. Applications to the Clerk, Lincoln.

Liverpool Infectious Diseases Hospital.—Assistant Resident Medical Officer, unmarried. Salary £80 per annum, with board, washing, and lodging. Applications to the Town Clerk, Town Clerk's Office, Liverpool.

Manchester.—Junior Assistant to the Medical Officer of Health. Salary £200 per annum. Applications to the Town Clerk, Town Hall, Manchester.

Morpeth Dispensary.—House surgeon, unmarried. Salary £106 per annum, with furnished rooms, coals, gas, and attendance.

North Riding County Asylum, Clifton, York.—Senior Assistant Medical Officer, unmarried. Salary commencing at £150, with board, apartments, washing, and attendance.

Stockport Infirmary.—Assistant House and Visiting Surgeon. Salary £70 per annum, with board, washing and residence.

Sunderland Infirmary.—House Surgeon. Salary £80, rising £10 annually to £100, with board and residence.

Weston-super-Mare Hospital.—House Surgeon, unmarried. Salary £100 per annum, with board and residence in the hospital.

Wolverhampton and Staffordshire General Hospital.—House Physician for two years. Salary £100 a year, with board, lodging and washing.

Births.

ANDERSON.—On April 10th, at Dencliff House, Ashford, Middlesex the wife of Alex. J. Anderson, M.B., C.M. Edin., of a daughter.

LOBBAIN-SMITH.—On April 11th, at Westbourne, Windsor Avenue, Belfast, the wife of J. Lobbain-Smith, M.D., of a daughter.

WAINWRIGHT.—On April 10th, at 118, Sandgate Road, Folkestone, the wife of Lennox Wainwright, M.D., M.R.C.S., of a son.

Marriages.

HOPE-SMITH—PITTS.—On April 11th, at Marylebone Parish Church, London, W., Arthur Hope-Smith, third son of Dr. Heywood Smith, to Carrie Clara, youngest daughter of the late S. E. Pitts.

WOODHEAD WILLIAMS.—On April 11th, at Milton Congregational Chapel, Herbert M. Woodhead, M.B., of Sale, Cheshire, to Mabel Cecilia, daughter of J. E. Willans, of Rose Hill, Huddersfield.

Deaths.

BOYLE-TRAVERS.—On April 8th, at Farsild, Rostellan, co. Cork. Robert Boyle-Travers, F.R.C.S., aged 77 years.

COCKCROFT.—On April 12th, at Manor Lodge, Chislehurst, Thomas H. Cockcroft, M.D., aged 74.

JACKMAN.—On April 8th, Arthur Croome, third son of Thomas S. H. Jackman, L.R.C.P., of 11, Stoke Newington Road, N.

OAKLEY.—On April 13th, at Frognal, Hampstead, Harry C. Oakley, L.R.C.P., L.R.C.S. Edin., aged 46, eldest surviving son of Sir Hy. Oakley.

OLDHAM.—On April 4th, at Haselmere, Sireatham Hill, S.W., George St. John Oldham L.R.C.S., L.R.C.P., late of Clapham, eldest son of the late George St. John Oldham, M.D., of Castleknock, co. Dublin.

PRIESTLEY.—On April 11th, at 17, Hertford Street, Mayfair, London, Sir William Overend Priestley, M.P., M.D., LL.D., aged 69 years.

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THE PATHOLOGY AND TREATMENT OF PNEUMONIA. (a)

By NATHAN RAW, M.D.,

Medical Superintendent Mill Road Infirmary; Consulting Physician, Walton Workhouse, Liverpool.

MR. PRESIDENT AND GENTLEMEN.—I feel that no apology is necessary on my part in presenting to the notice of this Society a few remarks on such a vital and all important subject as pneumonia. A subject of such vast importance, from the fact of its pathology being uncertain and unsettled, and because it has claimed and unfortunately continues to claim thousands of victims each year.

Pneumonia occurs in such various forms both as a primary and secondary affection that it would be impossible in the short space at my disposal to discuss them here, and I wish to-night to confine my attention to that form of lung inflammation which whether fatal or not is characterised by sudden onset, well-marked symptoms, distinct anatomical changes and limited duration, generally termed acute lobar pneumonia.

First, with regard to the pathology of the disease. Is pneumonia to be classed as a purely inflammatory disease caused by a chill, or is it a specific infectious disease having as its sole cause a definite and constant micro-organism?

During the last twelve years I have examined 1,047 cases of pneumonia in hospital, and of that number 246 patients died of the disease. In a large number of the cases careful microscopical and bacteriological examinations were made by my colleagues and myself, together with careful post-mortems in over 200 cases.

Etiology.—A low-lying and varying climate, with prevailing cold, dry, penetrating winds, is shown by statistics to have a marked effect upon the incidence of, and the mortality from, pneumonia.

It is common all over Temperate Europe, United States, Australia, New Zealand, and South Africa. It is less common in the Tropics, but in the Highlands of Central Asia and India it is not infrequent. In this country the period from November to January is the most common.

Individual Constitution.—It was at one time thought that pneumonia, unlike other diseases, attacked chiefly the robust and strong, but careful examination has shown that this is far from true, and that the individual at the time of attack was in a condition of depressed vitality. Debilitating causes of all sorts render individuals more susceptible. Alcoholism is the most potent predisposing factor, and I have now come to look upon the previous alcoholic condition of a patient as the arbiter of his life when attacked by pneumonia. It is then that the

temperate person requires the resisting power which has been frittered away by the drunkard, and it is rare to see a really alcoholic subject weather an attack of virulent pneumonia.

Chill.—It is generally admitted that pneumonia is connected with cold, with north winds and with sudden changes in temperature, and it is a matter of common experience that a chill may be followed in different persons by very varying effects, and that if several persons are exposed to a severe chill some escape altogether, whilst in others serious illness results.

One may develop rheumatic fever, another pleurisy, another pneumonia. This seems to be due to a varying resisting power, either due to the natural strength of the person, or to a process of what is called hardening. Some people never wear an overcoat, can sit in draughts with impunity, and never seem to take cold. Inflammation itself is a much more variable condition than it was once thought to be. It differs as the cause which produces it, and as the organ or tissue which reacts to it, and pneumonia seems in some respects to be an example of a chill "striking inwards," which often undoubtedly produces acute Bright's, colitis, pleurisy and even myelitis.

To assume that pneumonia is always caused by cold, and is purely and simply inflammation of the lung tissue would be unjustifiable in the light of our present knowledge. We have the hyperæmia and softening of the tissue, which are the characteristic signs of acute inflammation everywhere. We have the pyrexia and other febrile symptoms which also attend acute inflammation. We have the exudation of liquor sanguinis, with leucocytes and fibrin. The last stage of the process is purulent infiltration of the lung, and, lastly, in every case of pneumonic hepatisation we find the obviously related pleurisy, which no one can deny to be inflammation.

It is true that pneumonia cannot be produced by injury or by ordinary irritants, as is proved by experiment. The few supposed cases of traumatic pneumonia are probably coincidences. The process is a special kind of inflammation. Much the same is true of the tubal nephritis of acute Bright's disease, which is no doubt inflammation, but inflammation of a peculiar kind. Admitting for a moment that pneumonia is truly inflammation of the lungs, are all its symptoms due to this local inflammation?

This certainly cannot be maintained, for sometimes we find the symptoms precede the signs of hepatisation by several days. The temperature and the number of respirations fall when the crisis comes, and yet the inflammatory conditions remain the same, the hepatisation is several days in clearing up, whilst all the time the patient is comfortable and comparatively at ease.

On the other hand the differences between pneumonia and the general infective diseases, such as typhus, small-pox, and scarlet fever belong, are very great. It resembles them in its sudden onset, in its

(a) Paper read before the Medical Institution, Liverpool, on January 21st, 1900.

pyrexia, its definite course, and its limited duration, but in the vast majority of cases it is sporadic and idiopathic.

It does not in ordinary experience arise from previous cases of pneumonia, nor produce fresh ones. It does not protect from future attacks, but rather disposes to them. The fact is it cannot be fitted into any current classification with certainty.

Bacteriology.—The first important contribution to the bacteriology of pneumonia was made by Friedlander in 1882, who described capsulated diplococci as of constant occurrence in the exudation of the pulmonary alveoli the micrococcus lanceolatus or diplococcus pneumoniae of Fraenkel.

Sternberg, in 1880, inoculated rabbits with his own saliva and isolated micrococcus, but no suspicion entered his mind that the organism was concerned in the production of acute lobar pneumonia. Fraenkel, in 1884, determined this, and considerable confusion existed between this and the pneumo-bacillus of Friedlander.

The diplococcus is now admitted to be present in a very large proportion of cases of croupous pneumonia, but scarcely any peculiarity in the organism is constant, a large number of varieties have been cultivated, and its kinship to the streptococcus pyogenes is regarded by many observers as very close.

My own experience, after examining a very large number of sputa is confirmatory of the fact that the organism most constantly present is the diplococcus of Fraenkel, although every variety of cocci may be present with it, and what part these organisms play in the causation of the disease is still uncertain. On the other hand I have repeatedly failed to find any diplococci even in very virulent attacks of pneumonia, and what appears to be incredible, I have repeatedly stained all sorts of cocci and diplococci from my own throat, which one could not distinguish from these found in pneumonia.

Clinically.—The infectious nature of pneumonia was recognised long before we knew anything of the pneumococcus. First, the disease is similar to other diseases of an infectious nature in its onset. It may be endemic in houses, gaols, schools and barracks. It is not uncommon to have two or three members of the same family attacked, and I have on two occasions seen both husband and wife ill at the same time with definite pneumonia. Among numerous epidemics, Middlesborough in our own country is the most typical, and Ballard reported 682 persons attacked by pneumonia, with a mortality of 21 per cent. The usual and often fatal complications of pneumonia must be now looked upon as direct extensions of the disease caused by a micro-organism, the chief ones being pleurisy, pericarditis, endocarditis, peritonitis, meningitis, otitis media, and nephritis. In all these complications the diplococcus pneumoniae has been found at the same time as in the lung, which to my mind is strong evidence of its specific nature. In October last a girl, æt. 25, was admitted into Mill Road Infirmary with an acute attack of pneumonia on the third day. The day after admission she complained of blindness in the left eye, which rapidly extended to the right, with severe headache, and rapid delirium. I suspected pneumococcal meningitis, and at the post-mortem there was a thick layer of lymph round the optic commissure extending on to the frontal lobes. Microscopically, diplococci were found in abundance and were exactly similar to the organisms found in the lung which was in a state of lobar pneumonia.

To sum up the evidence regarding the bacteriology of the disease, I am of opinion that the disease is caused by a specific virus, although I must admit that the arguments are by no means conclusive.

The work of Sternberg is in support of the view

that the organisms associated with pneumonia are normally present in the mouth and nose, and that before infection can occur there must be a condition of lowered vitality on the part of the individual, rendering him liable to attack or at least unable to resist the action of the organisms.

All of us in this room have seen patients suffering from pneumonia, and one has only to look at a case in the acute stage of the disease to see that the patient is suffering from some specific form of poisoning of his system. There he lies helplessly on his back, his face flushed, his expression anxious, evidently suffocating and yet not so. His skin is harsh and dry, temperature high, pulse rapid and out of all proportion to his respirations, which are short, spasmodic, painful, and embarrassed. The period of incubation is unknown, but I am inclined to believe it is very short, and probably only a day or two. Now, what is the nature of the poison? It is fair to assume that the toxins are the product of the pneumococci rapidly generated and as rapidly absorbed, and that the crisis which is the most important feature of the disease is the moment when a sufficient amount of a substance named anti-pneumotoxin has been generated in the blood to exactly counteract the action of the pneumotoxin. I feel confident that in the near future we may be able to produce this anti-pneumotoxin experimentally, and so by injecting it early in the disease cut short the attack in a similar and as efficacious a manner as in diphtheria.

As to how the pneumococcus gains entrance into the system it is not the intention of this paper to discuss, but it is presumably omnipresent especially in towns and cities, and wherever human beings congregate, and in fact the organisms have been demonstrated by many observers from healthy subjects, but so long as the individual remains in a good sound condition of health, they do no harm, but as soon as his vitality is reduced, either by a chill, an attack of influenza, alcoholism or other debilitating conditions, then they have their opportunity which they seize at once, and pneumonia results. Pneumonia is very rare at sea and in cold climates, this is probably due to the fact that the atmosphere is almost pure and contains no organisms, but as soon as sailors come to towns and endure the same cold as when at sea, they are just as liable to pneumonia as other people.

Now, one word with regard to the contagious nature of pneumonia. When I commenced this paper, for the purpose of making more accurate observations, I decided to admit all cases of pneumonia into one ward, and I have come to the conclusion that this is a mistake. Three patients in one month, all of whom were admitted, and had been resident for some time with different complaints, with alcoholism as the most prominent feature, developed pneumonia. The attacks undoubtedly developed in the ward, all the patients were sleeping in the pneumonia area, and all were peculiarly acute and virile. As I said before all these patients were chronic alcoholics, and two of them had had delirium tremens. My own theory on this point is that the atmosphere of a ward is liable to be too highly charged with the organisms of pneumonia to a point which is dangerous, and that when this takes place the most debilitated constitutions are liable to be attacked. It is true I have never seen a doctor or a nurse develop pneumonia, but then they are not chronic alcoholics. I have also come to the conclusion that typhoid fever ought not to be treated in a general ward, beyond a certain percentage of cases to each ward on the same principle.

Prognosis.—In discussing the prognosis in a case of primary pneumonia, the whole circumstances of the case must be carefully taken into account, but I

will only here refer to a few of the most weighty. First, the age of the patient. In children and young people the prognosis is as a rule good. Between 20 and 35 or 40 the pneumonia of young adults is still favourable on the whole, but at this time of life it is common for both lungs to be affected. After 40 pneumonia is always a serious disease, and in my opinion the prognosis to a very great extent then depends upon the previous intemperate habits of the patient, on his being in good bodily condition on the one hand, nor on the other under fed and reduced by want and misery; on his being early put to bed under judicious treatment, on the extent of the lung affected, the association with influenza, the condition of the kidneys and heart, and the presence of cyanosis. Statistics show more recoveries in private practice than in hospital, and this is not surprising, as the patient is put to bed at once and the doctor is in immediate attendance in private, whereas in hospitals, patients are frequently brought on the fourth, fifth, sixth or even seventh day of the disease with his system poisoned and too ill to undergo the process of being removed from his bed to hospital.

Treatment.—Now a few words in conclusion regarding the treatment of the disease. I will not weary you in enumerating all the various specifics and methods of treatment that have been employed in centuries past, reflecting as they do the various theories of disease and the changing practice of therapeutics.

Pneumonia is a self-limited disease which can neither be aborted nor cut short by any known means. It may terminate favourably in a large number of cases without a single dose of medicine having been administered. In the words of Osler, there is no specific treatment for pneumonia, and he advises the young practitioner to bear in mind that patients are more often damaged than helped by the promiscuous drugging, which is still only too prevalent in America.

Although this is true in general, an enormous amount of good can be done by the physician in treating the disease intelligently, by carefully watching the onset of symptoms, and the progress of the attack.

The General Management of a Case.—The room should be light and bright, letting in the sunshine if possible, and thoroughly well ventilated. The patient should wear a thin light flannel jacket, and not be too overburdened with heavy coverings. He should be gently sponged with tepid water daily, and after the diagnosis has been established should not be examined more than is necessary. Many physicians prescribe three or five grains of calomel at the outset of the disease, followed by an aperient draught, and stimulate the skin by a saline draught every three or four hours, with occasionally two grains of quinine included. This practice I have found universally beneficial and never does any harm.

The effect of this treatment is to lower arterial tension and diminish venous engorgement by increasing the secretion from the skin and bowels. The severe excruciating pain on the side so often seen is due to the stretching of the inflamed pleura by the engorged lung, and is often relieved by the application of an ice-bag. When the ice-bag fails, as it sometimes does, I have found the old-fashioned mustard and linseed poultice have an excellent effect, often relieving the pain as if by magic. In some cases it is necessary to give a hypodermic injection of morphia, but this drug should be used with great caution, as I have seen alarming symptoms follow its use, chiefly diminished respiration, accumulation of secretion in the bronchi and extreme cyanosis.

The diet should from the first be fluid and sustaining, consisting chiefly of milk, abundance of pure water, lemonade, together with eggs and beef juice.

Certain measures are believed to have an effect in controlling the disease, chief among them being the old practice of bleeding. For centuries this was adopted, advocated by Celsus and Sydenham and a host of other authorities in their time. The practice was carried to far greater excess on the Continent, and especially Italy, where each patient was bled 12 and 15 times apiece, it being then considered the only hope. The plan was to remove some 10 pounds of their vital fluid, morning, noon, and night; on the first day two pounds was taken, on the second day he was bled twice, and after that once a day as long as he lived. With this draining of blood considerable quantities of tartar emetic were given, and it is hardly necessary to state the mortality was terrible.

The practice slowly diminished until the publication of a series of cases by Hughes Bennett, of Edinburgh, appeared in a book called "The Restorative Treatment of Pneumonia." In this remarkable book he proved that the subjects of pneumonia might survive without medical interference, and did best with sustaining treatment. Dr. Waters, of Liverpool, published a long list of cases with most unusually good results. In fact he had only two deaths out of a series of 77 severe cases. His treatment was restorative, and included in many cases alcohol in large quantities. I am afraid the present statistics would not bear favourable comparison with those of Dr. Waters, but it is possible the type of the disease has changed, or the patients have less resisting power. It is, however, a good practice occasionally in plethoric, robust patients to bleed at the onset of the disease, and I have frequently seen excellent effects from extracting twenty ounces from the arm. When there is associated fibrosis of the kidneys, with greatly increased arterial tension, venesection has marked temporary benefit, but does not seem to affect the ultimate result.

Certain drugs are credited with the power of reducing the intensity and shortening the attack. *Veratrum viride* still holds a place, two to five minims of the tincture being given every two or three hours. Tartar emetic used to be given, but rarely now. To a third drug, *digitalis*, a lot has been attributed, but on the whole it has not been a success.

If the heart's action becomes very rapid with a quick and irregular soft pulse it sometimes does good when given in large doses, say 15 to 20 minims of the tincture every two hours until two drachms are given, or a hypodermic of digitalin $\frac{1}{10}$ to $\frac{1}{8}$ of a grain has a marked temporary effect in tiding a patient over a critical period. I would like to draw especial attention to a method adopted by Dr. G. Balfour, of Edinburgh, viz., chloral and *digitalis*, 10 grains of chloral with $\frac{1}{3}$ ss of infusion of *digitalis* every four hours daily. The stage of pyrexia and delirium has been followed in a large number of my cases with excellent effects. It gives the patient most relief from his sufferings, often keeps him dozing and free from pain, and seems to control the delirium and sleeplessness. I have never seen any drawbacks from its use.

With regard to the antipyretic treatment both by drugs and the application of cold to the surface, phenacetin, antipyrin, antifebrin, and quinine have been thoroughly tried, and the general opinion seems to be that they do not favourably influence the disease. It is, however, most essential to carefully control the temperature by sponging the body with iced water if there is any tendency to hyperpyrexia. Carbonate of ammonia is an excellent drug, and given in doses acts as a stimulant and expectorant, it however sometimes upsets digestion and then must be discontinued. The tendency to cardiac failure is the great stumbling block to the physician, and it is hard to stand by and see your patients slowly but

surely develop the feeble and irregular pulse which is the sure omen of dissolution, even when the course of the lung lesion has progressed satisfactorily. It is now that the resources of the physician are tested to the utmost. Is the heart weakness due to the progressive distension and over filling of the right heart? Too often the progressive cardiac failure is due to the toxins, poisoning the nerve centres and directly affecting the heart muscle.

It is now that alcohol is indicated, which must be given in large doses say six, eight, ten or twelve ounces of good brandy in 24 hours. By combining alcohol and digitalis the temporary stimulating effect upon the heart of the alcohol and the more permanent and tonic effect of the digitalis are best obtained. The brandy or whisky must be good.

It many cases of pneumonia—in fact, I should say a majority—alcohol in any form is not required, but when it is indicated nothing else seems to take its place, no other drug acts so quickly and surely, and it certainly saves many lives even when the patient seems to be “in extremis.”

Strychnia is a most valuable cardiac tonic, and given hypodermically in doses of $\frac{1}{20}$, or even $\frac{1}{10}$ of a grain will have a miraculous effect upon the heart in some cases.

I am sorry to say that my experience with oxygen gas has not been on the whole good. I have used it in 65 cases, and have only seen real benefit in two cases, and these were double pneumonias. It is rare for a patient to die from suffocation, and it has been said that oxygen will cause the disease to spread from one lung to another, but this has not been proved. The use of saline injections has lately been advocated with regard to the antitoxic treatment. This is still in the trial stage. The brothers Klemperer, Auld, and Washbourn have reported favourable results. There are two sources from which the serum may be obtained, either from the blood of the patient who has recovered from the disease, or from an animal rendered immune, from the injection of a gradually increased dose of the pneumococcus. I would much like to extract 20 ounces of serum from the patients who have just recovered, if they would give it me, as I feel it is the more certain source. Perhaps in the future I may be able to report this. In conclusion, pneumonia seems to occupy a middle place between specific fevers and local inflammation, with many points in common with both. At one time it will present almost exclusively the characters of a local disease, at another those of a virulent specific poison, especially if associated with influenza. Some cases will recover without special treatment, and others are hopeless from the beginning; but I feel sure that the treatment of the future will be the antitoxic treatment, used early so as to abort the disease by destroying its toxins.

THE TREATMENT OF TALIPES EQUINO-VARUS

BY

LENGTHENING THE TENDO-ACHILLIS. (a)

By DR. R. A. HIBBS,
Of New York.

I RECENTLY presented before the New York Academy of Medicine five patients affected with talipes equino-varus, the result of infantile paralysis, on whom I had performed a new operation as follows:—The tendo Achillis having been exposed by a parallel incision $1\frac{1}{2}$ inches in length, made to its outer side, it was cut transversely within half an inch of its insertion, through two-thirds of its substance, and with

the turned knife it was then split upward a certain distance. A quarter of an inch above the end of the longitudinal cut another transverse cut was made from the opposite side through two-thirds of the substance of the tendon, and the knife being turned the tendon was again split to within quarter inch of the first transverse incision. Then the tendon was severed in such a manner as to secure its lengthening and at the same time to preserve its continuity. In Fig. 1 the first transverse cut would be from E to C, the first longitudinal from C to D, the second transverse from C to B, and the

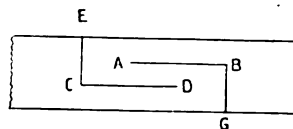


FIG. I.



FIG. II.

second longitudinal from B to A. When traction was applied lengthening would occur as shown in Fig. 2, and it would be equal to the sum of the two longitudinal cuts minus the sum of the two laps of quarter of an inch each. In Fig. 1, if C D is half an inch, B A half an inch, A to E-C quarter of an inch, and D to G B quarter of an inch, then the lengthening would be (half an inch plus half an inch) or 1 inch minus (quarter of an inch plus quarter of an inch), minus half an inch, or half an inch. It is a matter of choice whether the longitudinal or the transverse cuts were made first, but it is important that the skin incision should be to the outer side of the tendon in order to prevent the scar from falling directly over the tendon which might be rubbed by the shoe. I have learned since operating by this method that it had been practised in a case of traumatic equinus by Sporon, a Dane (“Hospitals-tidende” 3rd series. Vol. IX. No. 50, 1891).

CASE I.—In a girl, *æt.* 8, a short tendo-Achillis had prevented flexion of the right foot within 10 degs. from a right angle. It was lengthened by this method on September 22nd, 1899, and the foot was fixed at a right angle. In two weeks slight voluntary motion was allowed and the muscle received daily exercise with some assistance from the attendant. After half an inch lengthening had been secured, there was positive resistance to any further flexion of the foot than was allowed by the lengthening. The child walked with strong control of the os calcis.

CASE II.—In a girl, *æt.* 12, flexion of the left foot was impossible within 15 degs. from a right angle. The tendon was lengthened three-quarters of an inch on July 6th, 1899. With suitable after-treatment the result was an excellent position of the foot with strong action of the muscles of the calf.

CASE III.—In a girl, *æt.* 14, flexion of the right foot was prevented within 10 degs. from a right angle. The tendon was lengthened $1\frac{1}{2}$ inches on June 16th, 1899, an unusual amount in order to relieve extreme valgus, with resulting good control of the os calcis. As the valgus was recurring a tendon grafting would be done.

CASE IV.—In a girl, *æt.* 6, the left foot was inflexible within 45 degs. from a right angle, appearing to be almost in a straight line with the leg. The tendon was lengthened $1\frac{1}{2}$ inches on June 16th, 1899, and the foot fixed at a right angle. It was believed that an ordinary tenotomy would have been followed

(a) For these notes we are indebted to the Chairman of the Orthopedic Section of the New York Acad. of Med., Dr. A. B. Judson.

by loss of usefulness of the calf muscles. It was seen, however, that this action was excellent.

CASE V.—In a girl, *æt.* 14, the right foot had been inflexible within 15 degs. from the right angle, and the tendon was lengthened three-quarters of an inch on June 16th, 1899, and the foot fixed at 90 degs. The muscle and tendon showed enough strength to sustain the weight of the body on tip-toe, and this had been true of all the cases presented. In no case had an effort been made to correct the equinus beyond a right angle. Further correction might be desirable in congenital, but not in acquired equinus.

That the strength of a tendon lengthened in this way is not seriously impaired, is proved by the observation that in every case there had been resistance to the carrying of the flexion beyond the limit allowed by the operation and also by the ability of the muscle and tendon to sustain the body on tip-toe. The process of repair had been rapidly completed after operation by this method, which presents obvious advantages over those in which sutures are applied to the tendon. But the greatest advantage has been found in the readiness and certainty with which the desired amount of lengthening could be exactly secured.

A perfect gait requires the "spring" or elastic quality imparted by the muscles which enables the anterior part of the foot to sustain the weight of the body in walking. Without this power the gait would be that of one who had a wooden foot, or a foot affected with talipes calcaneus. In equinus following infantile paralysis, it was probable that the muscles were more shortened than the tendon, and as lengthening the muscle was generally impossible, operative relief had to be sought by lengthening the tendon. In operating, however, it was important on the one hand to avoid leaving the tendon so long as to impair the action of the muscle, and on the other hand to avoid leaving it so short that the equinus would not be sufficiently overcome. This method enabled the operator to maintain exactly the proper relation between the length of the tendon and that of the muscle. By subcutaneous tenotomy the equinus is readily corrected, but in many cases the result is a serious defect in the gait from undue lengthening of the tendon and resulting shortening and inefficiency of the muscle.

THE PATHOLOGY OF ACUTE MYELITIS. (a)

By PROFESSOR MAYER,
of Berlin.

AFTER relating the history of seven cases of myelitis the author contended that the disease had a variety of definitions, although it was commonly known as an inflammation of the spinal cord, but he experienced a difficulty in differentiating between the various groups of inflammation and softening of the cord structures. The clinical history of the seven cases were as follows:—

1st. A male patient, *æt.* 47, after raising a heavy weight felt a weakness in the movements of all the limbs; eight days afterwards he died. From the third to the seventh cervical segments there was a central softening.

2nd. A male, *æt.* 57, took a sudden pain across the loins followed by paraplegia, bladder and bowel disturbance. He died in 28 days after this attack. At the post-mortem a necrotic centre was found in the cord from the third to the fifth dorsal segment down through the whole lumbar nerve structure.

3rd. Male, *æt.* 50, had syphilis 16 years previously;

was suddenly attacked with paraplegia; four days later with paralysis in all the extremities; sensibility, bladder and bowels all disturbed. Forty days later he died.

4th. Male, *æt.* 64; paraplegia and death after 22 days.

5th. Male, *æt.* 68; for a long time past had suffered from imperfect vision (neuritis optica). Suddenly paraplegia appeared, and he died after 17 days.

6th. Male, *æt.* 50; 15 years' ago he had syphilis. He was suddenly seized with paraplegia, and died 32 days after the onset of the paralysis.

7th. Asyphilitic; disease more chronic in character; died within six months after the advent of the paralysis.

In all these cases the microscope gives one common picture, viz., a degeneration of the white and grey substance of the cord, although two forms may be easily defined microscopically. The first may be termed the perforated, with a swollen and much destroyed axis cylinder, sometimes with a necrosis of the tissue and an accumulation detritus. In the perforations or spaces fatty granular cells are met with. The section also varies according as it is central or peripheral; the latter is usually wedge shape, with its widest part at the periphery; the former is circular or oval. The cause of these appearances depends on the vascular supply. We are therefore led to examine the perivascular and intravascular supply for its origin.

When the vessels are more minutely examined they were found to be thickened and hard with fatty granules in the perivascular spaces. Sometimes hæmorrhage may be observed from rupture of these fine structures, but in the microscope no difference can be detected between the syphilitic and the non-syphilitic.

The second form may be termed the infiltration or inflammatory form. This form only appeared once in the above seven examples. The question now arises, is this solitary case with fine cellular infiltration the only or real form of acute myelitis or do the two forms fall into the same category? In the cases of the necrosis, embolism seems to have been the cause of the immediate changes, though the vascular changes were prior. If the embolism could be separated from the affected vessels some distinction might be possible and a difference recognised.

PROTARGOL

VERSUS

NITRATE OF SILVER.

By JOHN MOIR, L.R.C.S.E., L.R.C.P.Ed.

THE most eminent surgeon of his day, Professor Syme, of Edinburgh, used to say, "the best remedies and instruments were the simplest," and the more we aimed at simplicity, the more certain were we to cure disease, as well as to prevent it. Although he used the statement as regards hernia chiefly, yet it has an undoubted general application, and, as time goes on, each new product of the chemist's laboratory, if it is to live and be of any use in medical or surgical treatment, must conform to this standard. Now, in the local treatment of gonorrhœa, conjunctivitis, &c., we have undoubtedly such a remedy in protargol, not only so, but the remedy. A recent writer asserts that it is "not simply a mixture of protein and a silver salt, but a true chemical combination. It acts as a strong antiseptic in 1 to 5 per cent. solution, exerting a marked effect upon gonococci, while it does not irritate the tissues. Protargol, without doubt, should prove of immense service in other surgical domains because of its non-irritating

(a) Abstract of paper read before the Medical Society of Berlin.

properties, than in the treatment of urethral inflammation alone." Its chief value above other otherwise equally efficient preparations, is its non-irritating, non-staining and stable quality, with its ready solubility in water. It also has a better penetrating effect on the tissues than any other silver preparation, and has been proved to be an excellent antiseptic in the curative treatment of wounds and ulcers. On all these grounds it is certain that it holds easily the first place for external use in comparison with other preparations or silver combination.

I have used it in hollow cacao-butter bougies, introduced into the urethra at bedtime in several cases with the best results, the bougie being kept in place until it dissolved, with a tiny pledget of cotton wool, in $\frac{1}{2}$ grain doses. I have also used it as an injection in other cases in $\frac{1}{2}$ to $\frac{1}{4}$ grain doses dissolved in water, and have found that there was very little complaint of irritation, and in some cases none at all. The remedy is simple, comparatively painless, and in about two weeks' time very effectual. From its antiseptic properties it is also a preventive of gonorrhoea, when used at the proper time, as well as curative in the later stages, after the disease has manifested itself. It is cleanly, also, and has none of the disadvantages of the ordinary injections nor has it in any case, in my hands, produced inflammation higher up the urethra, nor epididymitis. It is therefore safer and more reliable than any other agent one can use in these cases. I have had over twelve months' experience with it, so that I can speak positively of its value and superiority, for the various reasons I have enumerated, to any other topical application known.

Taking life as it is, and not as it ought to be, among our civil population, as well as at our military stations and seaport towns, it is then a matter of the first importance that we have, as we have in protargol, an agent of such value and possessing so many advantages, so much so that at the Lock Hospital in London it has superseded all other local remedies.

Mr. J. E. Lane, F.R.C.S., Surgeon to the Lock, and to the out-patients at St. Mary's Hospital, in the *Practitioner*, June 1898, has given his experiences of its use at length, and still more fully, after further trial, in his report in "The Year Book of Treatment" for 1899, where he states that "from the experience of the writer, extending over nearly a year, protargol far surpasses any remedy yet introduced as an adjunct to the therapeutics of gonorrhoea. Every acute case in the wards of the London Lock Hospital and in the Out-patient department of a general hospital has during that time been treated with this substance, and, though no actual figures can be given, with the result of shortening the period of the treatment and of leaving the patient permanently cured. In a large number of the cases the presence of the gonococcus was verified on commencing the treatment. The fact that none of the patients have presented themselves complaining of relapse may be taken as an argument against the return of the disease. In cases of chronic and of posterior urethritis similar good results have been met with, though in such cases the solution has been applied topically by means of the endoscope, or by deep injections with a Guyon's syringe, and in a strength of solution of 20 or 30 per cent.

Mr. H. J. W. Martin, M.R.C.S., of Mill Hill, states that protargol has done all that was said in its favour in his hands. In one case in particular he used it in gonorrhoea of six weeks standing, with the result that the patient was so thoroughly cured as to get married without postponing the day, and there were no after bad results. As a prophylactic after coitus, should there be any suspicious indications a triturated solution of twenty parts of protargol, with ten of

glycerine and seventy of water, has been found useful, or a larger proportion of glycerine, 15 to 20 per cent.; and the same applies when used in the hollow cacao-butter bougies, an admixture of glycerine, increasing the efficacy of the remedy. It can be used as an injection three times a day, for two or three minutes twice a day, and for thirty minutes at night before retiring to bed, in the strength above stated without producing inflammation and with very slight irritation, and, although not claimed to be an absolute specific, there is abundant evidence to show that it has a powerful curative action in all cases of urethral gonorrhoea.

Mr. Sidney Stephenson, M.B., *Edinburgh Medical Journal*, March, 1900, in an article on "The Place of Protargol in Eye-work," has also shown its superiority to nitrate of silver, &c., in gonorrhoeal ophthalmia, conjunctivitis, and other affections of the eye, especially in purulent affections. I have found it very useful in one or two cases of ophthalmia neonatorum, when it is used sufficiently early it has always proved successful. Dr. W. L. Richardson, Dr. Alt, Dr. Cheney, and other ophthalmologists have published similar testimony.

In diseases of the nose, throat, and larynx (rhinolaryngology). Dr. Arthur Alexander, at the Royal University Clinic, Berlin, has met with remarkable success. He says that the Royal University Clinic, Berlin, for diseases of the throat and nose, retains the merit of being very careful as regards giving their opinion on the value of new remedies. Although many remedies, for local application, have been tested in the Clinic during its existence of twelve years, only a single one has been recommended by them to the profession as effective—menthol—which was introduced for the treatment of tuberculosis, and has in every respect maintained what was claimed for it, that it was indispensable to the laryngologist. He then in a paper, read at the Laryngological Society of Berlin on February 3rd, 1898, gives numerous cases of affections of the nose, larynx and pharynx, empyema (16 cases), hay fever, &c., treated by him, and concludes that the remedy gives valuable results in rhinolaryngological therapeutics. It is not of course pretended that protargol is alone useful in all these cases, or always superior to the other usual remedies, but that it is, *sine dubito*, a valuable addition to our armamentarium, and frequently succeeds where other remedies fail. For instance, Dr. Alexander says that in one case which he observed in the private practice of Prof. Fraenkel was that of a dentist who had tried everything to free himself from hay fever. The application of the galvano-cautery to the tuberculum septi caused the severest neuralgic pains, which made him absolutely incapable of doing work. A few injections of protargol into the nose changed the case completely, so that he became entirely and permanently free from any trouble.

Before summing up the results of my observations in the use of protargol in gonorrhoea, where alone, up to the present, I have had much opportunity of trying it, I must point, however, that, as a powder, or as an ointment, protargol has been found very serviceable in the treatment of wounds and ulcers, decidedly preferable to iodoform, the unpleasant smell being absent, its antiseptic and anodyne properties at least equal, and producing no irritation or discomfort by its use. In gonorrhoeal ophthalmia, suppurating, and infected wounds it is also of considerable value. The ointment may be made of 1 or 2 per cent. strength, or more, up to 5 or 10 per cent., with lanoline, vaseline, or the like base.

We have now considered protargol in its various general uses, and in looking at it specially we may take it that it is very useful, indeed, one might say most useful as a topical application in gonorrhoea.

Professor Finger, of Vienna, has pointed out that in dealing with the local treatment of gonorrhœa we have to consider three distinct eras. In the first, when the gonococcus was unknown, astringents were exclusively employed: sulphate of zinc, alum, &c., and nitrate of silver. In the second era, when the gonococcus has been discovered, the principle was adopted of treating not the inflammatory process alone, but also the gonococcus, its exciting cause, by means of drugs combining antiseptic and astringent, such as nitrate of silver, sublimate, argentamin, and potas. permang.; by this discovery antiseptic astringent therapeutics were understood and inaugurated. Quite recently, however, an improvement on this second stage has been arrived at, and the third era, so to speak, in gonorrhœal therapeutics entered upon, consisting in the employment of purely antiseptic, very slightly, or non-astringent drugs, including argonin, and finally protargol, recommended by Neisser.

The superior advantages of protargol then are its stability, easy solubility in water, the almost entire absence of irritating effects, and its great antiseptic qualities, through its properties as an organic combination of silver, a soluble silver albumen. On the other hand, the mild, almost non-astringent effect of protargol is almost nil in chronic cases, and here sulphate of copper, or nitrate of silver, will show better results, but in the early acute stages the use of protargol, as indicated in this paper, will render the use of these heroic remedies unnecessary; consequently, I submit that protargol should be used at the earliest stages to produce the best results.

If preferred to cacao-butter bougies, the gelatin-glycerine bougies, now so largely manufactured and in such general use, may be employed, and are quite as efficacious and as safe as if the remedy were used by injection, five to ten grains strength, or applied to the part on a metallic sound as an ointment. Not being in any way escharotic, the protargol does not require any cocaine, from my own knowledge of the use of these urethral bougies, I find that many patients use them in preference to an injection, and in one or two cases where they would not tolerate or listen to the idea of any injection whatsoever.

Then, again, protargol suppositories, made according to the formula of Dr. Albert H. Burr, on the same principle as the urethral bougie, for the treatment of female gonorrhœa, have been extensively used, and eminently successful. On the whole, therefore, we find a general consensus of opinion in favour of the more extensive use of protargol in the place of nitrate of silver where the silver treatment is indicated, and a genuine and painless antiseptic is required or demanded.

Medico-Chirurgical Items.

By GEORGE FOY, M.D., F.R.C.S.

VANADINATE OF SODIUM.

Good reports are furnished from the Paris and Lyons hospitals of the therapeutic properties of the vanadinate of sodium (*La Médecine Moderne*). MM. Debove, Labadie-Lageare, and Tapret state that the salts of vanadium quickly increase the appetite and stimulate nutrition, patients gaining from four to five kilogrammes a month whilst taking the drug.

Some difficulty in compounding vanadium salts is found from the energetic oxidising properties of the compounds. To avoid this granules of the vanadinate of sodium containing one milligramme each are now prepared by Parisian pharmacians, and named by him in honour of the Scandinavian Goddess, Freyja.

Vanadium was discovered in 1830 by Oefstrom, in a Swedish iron from Tabrog; it has also been found in Zinropan in Mexico, Wanlockhead in Scotland, and in

Chili. Recently Roscoe obtained an abundant supply of the metal in the old red sandstone of Cheshire.

The physiological effects of the salts were the subject of papers by Platt (*Lancet*), Drs. Dowdeswell (*J. Phys.*), Gamgee and Larmuth (*J. Aust. and Phys.*), Priestley (*Phil. Mon.*). Phormais published a monograph on their therapeutic action in 1890, as did Lowy in 1893.

DIET IN TYPHOID FEVER.

The Therapeutic Gazette writes:—While we are anxious to urge a more liberal feeding in typhoid fevers and other prolonged and exhausting febrile diseases, we are not advocates of the reckless administration of food in these conditions; but we are firmly convinced that a patient will generally resist the virulence of the disease better, maintain his strength, and have a more rapid convalescence when he is not confined strictly to a milk diet. The question of dietetics in typhoid fever is much like every other therapeutic question in the sense that the patient fares best when the physician does not adhere to any routine plan of treatment, but fits his drugs, his bathing, and his feeding to the needs of the individual case.

EPIDIDYMITIS.

Dr. Christian writes (*The Therapeutic Gazette*):—The testicle is first gently massaged with a small amount of a 20 per cent. guaiacol ointment made on lanoline. Some of this ointment is then spread on lint and applied over the affected testicle; the whole of the scrotum is enveloped in a layer of absorbent cotton, and over this is applied a snugly-fitting laced suspensory bandage. When the inflammation and pain have entirely subsided, and the testicle could be easily handled, the following ointment was used:—Blue ointment, belladonna ointment, ichthyol, and lanoline equal parts. Under this treatment the testicle was found in most cases to return to its normal condition in from two to three weeks.

CROTON OIL.

The use of croton oil is advocated by Dr. Bond (*Therapeutic Gazette*) under the following conditions:—

1. The average dose of the drug should be one-sixth of a drop, in which dose it acts gently, if fresh and of good quality.
2. In cases of great bowel inertia its action is usually gentle.
3. It is best given alone, in bread pill or with manna.
4. Its chief value is in removing poisonous material from an inert bowel.
5. It is contra-indicated in bowel inflammation and must be carefully guarded in impaction.
6. It is unsuitable for children.
7. It is indicated in many sorts of vomiting, in "biliousness" and in certain acute stercoraceous states as headache, asthma, local congestions, epilepsy and other forms of convulsions in the adult.

CITRIC ACID IN OZÆNA.

From his experience of the action of citric acid in ozæna Dr. Somers (*Therapeutic Gazette*) concludes:—

1. The drug is of great value in preventing the fetid odour of atrophic spinitis.
2. The successful action depends on its direct application to the diseased tissues, for this reason the removal of all foreign material is absolutely necessary.
3. After its use the ozæna usually remains absent from one to two days.
4. It exercises no direct action upon the morbid tissue in the direction of restoration to its normal functions.
5. Its action, unless regularly used, is transient.
6. To a moderate extent it inhibits scab formation.
7. It enables the rhinologist to successfully combat ozæna.

PAPILLOMATA OF PENIS.

In the case of vegetations multiple and sessile on the glans penis and foreskin, Dr. Silbromintz (*Rev. de S. Militar*) Madrid, recommends the growth to be surrounded with a layer of muslin or cotton wool, then to be carefully washed with Hoffman's liquor, and afterwards painted with the following:—

Collodion flexible	...	...	80 parts;
Resorcin	...	...	22 parts.
Mix.			

After a few applications the warts fall off, leaving a small excoriation, which rapidly heals under a few applications of the following powder:—

Carbonate of zinc	...	...	9 parts;
Subnitrate of bismuth	...	...	9 parts;
Resorcin	...	...	2 parts;
Talc in fine powder	...	...	80 parts.

Mix.

A MENTAL HOSPITAL IN SANTIAGO.

The city of Santiago, Chili (*La Semana Medica*), has erected within the past four years an hospital for the mentally afflicted, which is a great advance on all such institutions. It contains 22 great rooms, perfectly aired, luxuriously furnished, having great balconies, well protected by glass and thoroughly ventilated, which serve as dining and drawing-rooms for the inmates. The sanitary arrangements are very complete, the lavatories being numerous and well equipped; water is laid on in every quarter of the hospital, and the supply is practically inexhaustible. Kitchens for ordinary and invalid diet, furnished with all requisites are provided; all the premises are lit by electricity; clothes to suit the changes of weather are supplied. Provision is made for hydrotherapy, treatment by electricity, Röntgen rays, photography, and so forth. All medicines are prepared on the premises, and the pharmacy is supplied not alone with a great selection of drugs, but with every convenience for accurate compounding. There is an extern department for the treatment of nervous disorders which is largely attended by the poor of the city.

Amusements are constantly provided; large covered courts and open spaces for games; there is a large well-supplied library; a theatre and a concert room; in the latter artists from the *Conservatorio de Musica* of the city appear from time to time, and military bands play there frequently.

On Sundays the hospital is visited by numbers of families interested in its progress, who not unfrequently bring convalescent patients on visits for a few days. In 1897 there were 1,541 patients in the hospital, of these 57 per cent. were cured. The patients are made to take an interest in their surroundings by being employed in house duties under the supervision of the officials; at present 875 are employed.

This great hospital is the outcome of the generosity of four Chilean gentlemen whose names are worthy of remembrance:—Senores Pedro Monti, Barros Lucu, J. Castros, and M. Beca.

CRANECTOMY FOR INSANITY.

M. Spanboch (*La Semana Medica*), in the case of an insane boy, æt. 14, who was extremely vicious and very destructive, trepanned the parietal bones in six places, and cut away the portions of bone between the trepan cutting from before backwards. No good results followed until some months elapsed, and then the boy gradually discontinued his vicious and destructive habits, and finally became affectionate, obedient, and reasonable.

Spanboch attributes the good results to the greater space given for the growth of the cerebrum by the operation.

FRACTURE OF THE NECK OF THE FEMUR.

M. Nicolayson (*Nor. Med. Arch.*), from an experience of 21 cases of fracture of the leg treated by pegging the fragments together recommends the method.

Of the patients eight were males and 13 females. The peg he uses is of steel, triangular in shape, and 12 centimetres in length. Bringing the parts into apposition, he drives in the peg and places the leg immediately afterwards in any immovable position for from 10 to 12 weeks, removing the peg about the end of the third week. When the parts are pegged together pain almost immediately ceases, and in the great majority of cases no unpleasant results follow.

DESICCATED MAMMARY GLAND IN UTERINE AFFECTIONS.

According to *La Gynecologie*, Dr. Shober has found desiccated mammary glands useful in the treatment of fibrous tumours of the uterus. In three cases in whi

interference was urgently called for he found the treatment was most satisfactory; the menstrual periods occurred more regularly, were less abundant, less painful, and the tumours were lessened in size. The action of the gland in cases of menorrhagia uncomplicated with tumours, and in cases of subinvolution is very marked.

The author usually combines a small dose of strychnine with each dose of the gland, and sees that the bowels act daily.—*La Presse Médicale Belge*.

OPERATION FOR THE CURE OF OLD LARGE RETAINED HERNIA.

At a meeting of the New York State Medical Association Dr. Henry O. Marey, of Boston (*Ch. M. J.*), reported two cases where death was attributed to the greatly increased intra-abdominal pressure, produced by the return of the displaced organs.

In a consecutive list of about 500 operations undertaken for the cure of hernia by Dr. Marey, the cases reported are the only ones where the danger line seemed to be approached, where the intestinal canal was not involved.

It is interesting to note that this danger was foreseen, and discussed in the celebrated consultation of Sir A. Cooper and Mr. Cline on the case of the historian, Gibbon.

WARTS.

In these troublesome little growths *El Siglo Médico* recommends the following:—

Salicylic acid	...	...	5 parts;
Lanoline	...	...	50 parts;
Vaseline	...	...	50 parts;

Ft. ungt., or

Flowers of sulphur	...	...	10 parts;
Glycerine	...	...	25 parts;
Acetic acid	...	...	5 parts.

Ft. mistura.

The warts to be covered with the mixture and kept wet all day, or

Corrosive sublimate	...	...	1 part;
Collodion flexible	...	...	80 parts.

Ft. solutio.

To be painted on the growths.

A BULLET WOUND OF THE EAR.

Dr. D. Gabino Ruflanchas (*La Otorinolaring. Esja.*) of the Carcel Modelo de Madrid, reports the following notable case of a bullet embedded in the ear and extracted seventy days afterwards. The patient was a criminal who attempted to poison one of the prison warders. He escaped, but was recaptured on May 20th last. The officers of the police found him in bed, in which he had a revolver concealed. Placing the muzzle of the pistol at his right temple he fired and the ball, which was twelve millimetres in size, penetrated the bone immediately behind the temporo-maxillary articulation, traversed the anterior wall of the external auditory canal and became flattened against the posterior wall of the same; destroyed the tympanum, and occasioned so much injury to the internal ear that the sense of hearing was lost. Immediately after the wound he lost consciousness, and had a profuse bleeding from the ear and from the aperture of entrance of the bullet. He vomited freely, and the vomit was slightly tinged with blood. Blood poured so freely from the ear that the mattress on which he lay became saturated, and it continued to come freely until he was fetched to the House of Succour of the Cross Roads. Here the wound was dilated to allow of the extraction of the bullet, which the surgeons failed to find, and they were of opinion that the bleeding was due to an attempt by the patient to pull out the ossicles of the ear with a pair of fine pincers.

He was now fetched to Princess's Hospital, where he was detained, where they stayed the vomiting, and relieved the intense pain from which he suffered by hypodermics of morphia. The patient recovered consciousness; he complained of being very cold, and suffered from an intense thirst. He had violent pain in the temporal and parietal regions of the injured side, and he suffered acute agony when he moved the temporo-axillary articulation. His temperature stood at 103°F. for two days. He swallowed fluids without difficulty.

The sense of hearing was completely lost, and he com-

plained of a rumbling sound such as is produced by running the thumb firmly round a tambourine. Neuralgic pains shooting along the branches of the trifacial nerve of the injured side were very distressing. Gradually he gained health and strength, and on July 9th was committed to prison, where he came under the care of Dr. D. Gabino Ruffianhas. On examination, the prisoner was found to be suffering from a fistula, which opened in front of the tragus, and extended into the external auditory canal; from it an abundant fetid discharge was poured out.

Scrupulous cleanliness was secured by washing out the fistula, and on July 19th, a firm, dry body was seen lying at the end of the opening; this substance was caught with a pair of Péan's forceps; with greatest care and considerable force it was loosened and brought out; it was the bullet strongly flattened against the bone, and forming almost a cast of the place it occupied. For some days afterwards loosened pieces of bone came away, and a little later the wound ceased running, the fistula healed up, and ultimately the otorrhoea from which he suffered dried up.—*El Siglo Medico*: 2.352.

Transactions of Societies.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF PATHOLOGY.

MEETING OF FRIDAY, MARCH 23RD, 1900.

The President, Professor A. C. O'SULLIVAN, M.D.,
in the Chair.

EXHIBITS.

MR. ARTHUR BENSON showed a case of congenital polycoria in both eyes, in a man, *æt.* 40. The man had also got chronic glaucoma, for which (and not on account of the polycoria) he sought relief.

BRONCHOCELE REMOVED FOR DYSPNŒA.

MR. R. C. B. MAUNSELL showed the right lobe of a thyroid gland which he had removed from a girl, *æt.* 18. A moderate uniform enlargement of both lobes had existed without marked symptoms for 18 months, but within the last month the right lobe rapidly enlarged, and became tense, causing paroxysms of dyspnœa on exertion and stridor on deep inspiration. The specimen demonstrated one of the dangers of even a small bronchocele, as it contained a very tense blood cyst as large as a goose egg. The growth was removed by Kocher's transverse curved incision, and the result was most satisfactory, both in the relief of symptoms and in appearance.

CASE OF HUMAN ACTINOMYCOSIS ENDING FATALLY, WITH PATHOLOGICAL REPORT.

DR. H. E. LITTLEDALE reported the case of a man admitted to Sir P. Dun's Hospital, under care of Professor Bennett, on March 8th, with swelling on back of neck and at angle of left jaw. Several discharging sinuses and a fluctuating abscess, which was opened subsequently and the pus examined. Streptothrix threads, like convoluted chains of streptococci, found in the pus, but no clubs. No results from aerobic cultures; anaerobic not made. Microscopically the lesions were granulomata, breaking down into pus, which contained ring-like masses .15 mm. in diameter, composed of streptothrix threads, but no clubs were present. The lung apices were also affected with the streptothrix and tuberculosis, but tubercle bacilli, found post-mortem, could not be detected during life. Lungs were affected from the skin, as during life there was communication between the skin of the back and right lung. No further lesions except extensive amyloid change in all abdominal viscera. Patient died on November 28th from prolonged suppuration, which all surgical treatment, such as scraping out the sinuses and irrigation, failed to control. The patient positively stated that, though in attendance on cattle, there was no disease of any kind in the cattle of the district.

The PRESIDENT said he had examined the pus in this case microscopically, and he had discovered nothing in

the way of clubs or threads. He tried cultivation twice, and in the first attempt nothing grew, while in the second almost everything grew.

DR. BENNETT said that the suppuration as presented to him clinically was unlike anything he had seen before, and the only loop-hole by way of exclusion was the suggestion of actinomycosis. He thought it was dangerous to use potent injections, such as carbolic and perchloride of mercury solutions, so he adopted the compound tincture of benzoin as being least likely to poison.

DR. WALTER SMITH congratulated Dr. Bennett on diagnosing the first case occurring in human beings in Ireland. Considering that on the Continent forty or fifty cases had been recorded, its rarity in the United Kingdom was peculiar, and it was extremely unlikely that the disease could be overlooked. He found it difficult to accept the statement of a leading authority on the disease, that it was often cured by large doses of iodide of potassium, and that the injection of it would cause the destruction of the fungus locally.

DR. W. G. SMITH and PROFESSOR O'SULLIVAN showed an exhibit from a case of combined sclerosis of the spinal cord.

NOTE ON SPINAL DISLOCATION (FORWARDS).

MR. M'CAUSLAND read notes of the case of a man, *æt.* 50, previously healthy, except for bronchitis and asthma, who was admitted to Steeven's Hospital, on February 12, 1900, under Mr. M'CAUSLAND, patient having fallen fourteen feet off a ladder, on to back and shoulders. On examination there was complete paralysis and anaesthesia, and loss of reflexes in lower limbs, the abdomen was distended and tympanitic, respiration diaphragmatic, inspiration being short, expiration being lengthened. There was typical musculo-spinal paralysis on both sides, but the organs of sight, hearing, smell, and protrusion of tongue were all normal. No difficulty in swallowing, and no swelling or irregularity in the pharynx. Rotation and movement of the head from side to side caused no pain nor crepitus. Examination of the back showed no irregularity, or prominence, or depression, and no crepitus over any of the vertebral spines. The upright position was most easy for the patient, as he became breathless and cyanotic on lying down. No priapism, emission of semen, or involuntary passage of urine or faeces. Urine acid, 1022 sp.g., lithates abundant, trace of albumen and phosphates. *Treatment*—Complete rest, easily digested nourishment, icebag to spine, attention to bladder and rectum, and belladonna and ergot internally. Patient died in three hours' time, twenty hours after the accident. *Post-mortem*—A dislocation forwards of cervical vertebrae, with laceration of the cord and membranes. Bones were so locked that reduction would have been utterly impossible.

The Section then adjourned.

SHEFFIELD MEDICO-CHIRURGICAL SOCIETY

MEETING HELD APRIL 12TH, 1900.

The President, Dr. BURGESS, in the Chair.

DR. CAIRNS exhibited (1) an anencephalus showing also umbilical hernia and talipes varus; (2) a case of anatomical abnormality in the distribution of the tendons at the wrist.

MR. N. MILNER read notes of a case of progressive pernicious anaemia in a boy, *æt.* 12, and showed specimens.

DR. SINCLAIR WHITE showed a myomatous uterus.

DR. GORDON read notes of a case of

CIRRHOSIS OF LIVER IN AN INFANT,

æt. 14 months. He first saw the patient last December and found him suffering from slight enlargement of the liver. This increased in size until it could be felt below the umbilicus. In February ascites was present, and on April 2nd it was necessary to tap, when five pints of clear, straw-coloured fluid was withdrawn. The following day the liver was found to be considerably contracted, the edge being felt beneath the ribs. The fluid is collecting again and the present condition is such that

the child cannot live much longer. The parents are both healthy, and there is no history of either alcoholism or syphilis. There have been four children. The first suffers from curvature of the spine; the second is healthy, the third suffered similarly to the present case; the illness pursued a similar course, and ended fatally in about six months. A post-mortem was made, when the liver was found to be cirrhotic. These two children were reared in different parts of the town, and the latter case was brought up entirely on sterilised milk for twelve months. The spleen is not enlarged, and there is no jaundice. Having, after careful examination, excluded alcoholism and syphilis, it is difficult to assign a cause for the cirrhosis in this case.

Dr. ARTHUR HALL read a paper on

HYSTERIA IN BOYS.

A short account of six well-marked cases was given, in all of which during some part or other of their existence the diagnosis of cerebral or cerebellar organic disease was made. In the different cases, cerebral injury, tumour or meningitis were simulated, and the persistency with which symptoms were kept up day after day and week after week was quite surprising. Unhappiness in surroundings either at school or at work was the common factor, and a slight injury or illness the immediate starting-point. The diagnosis and exposure of the true condition by no means removed the symptoms at once.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, April 22nd, 1900.

EXPERIMENTAL RESEARCHES ON RABIES.

At the meeting of the Académie de Médecine, M. Nocard spoke on the post-mortem diagnosis of rabies in the dog, and said it was of vital importance to the public, as on the exactitude of the diagnosis might depend the life of bitten persons. When the animal succumbed to the natural evolution of the malady, the autopsy revealed the ordinary signs which determined the existence of the disease. But even in such cases it happened sometimes that every post-mortem sign was wanting, so that if the veterinary surgeon had not seen the animal alive he could not say with certainty if the dog had been affected with rabies or not. On the other hand, inoculation of the bulb did not permit to affirm the existence of the malady before the end of 15 or 20 days, that was to say, too late to advise patients to await the result of the inoculation before submitting themselves to the antirabic treatment. It was easy to understand consequently with what interest veterinary surgeons would hail a method which would render them able to say with certainty in a few hours that a suspected dog was or was not rabid.

Researches were undertaken to this end by M. Vallée, of Toulouse, who found in nine dogs which had died of rabies, disease of the nervous cells and the endothelial capsules of the plexiform ganglions of the pneumogastric described by Van Gehuchten. On the other hand, nothing of the kind was found in the same ganglions of healthy dogs. But were these lesions found in dogs sacrificed in the course of the rabies? When the result was positive, as was the rule where the animal succumbed to the natural evolution of the disease, it could be affirmed that the dog was mad; but when the result was negative, which frequently happened when the dog was killed immediately after biting a person it could not be affirmed that it was rabid or the reverse.

HYDROCELE.

The classical treatment of hydrocele is, as everyone knows, tapping, followed by injection of tincture of iodine. The method is certainly superior to many others having the same end in view, but still is not without certain drawbacks. The pain it excites is almost always very intense. Many patients bear it badly; some have fainted under the suffering, and more than once convulsions have been provoked. The testicle has been wounded rather frequently, provoking traumatic hematocele. For these and other reasons a substitute for tincture of iodine was sought for among various substances. In 1877, Dimmreicher, at the Medical Society of Vienna, recommended a solution of chloride of zinc, and two years afterwards Pallailon, of Paris, put into practice the treatment recommended by the Austrian surgeon, with very encouraging results.

Dr. Blanc, of St. Etienne, has just published a series of cases of hydrocele in boys and men of all ages, treated by the same method with most gratifying results.

The operation could not be more simple. A few drachms of liquid are first withdrawn (three or four) and then from five to twenty drops of a solution of chloride of zinc (1-10) are injected into tumour by means of an ordinary hypodermic syringe. The parts are then massaged so as to distribute the caustic in the sac. The operation, if it merits the name, terminates there. The immediate results vary. Generally reaction is slight, and the patient need not keep his bed. However, it is wise to counsel rest in bed for two days. After the injection a certain amount of pain is felt in the region of the testicle, radiating along the cord to the abdomen; the scrotum is slightly inflamed, giving the sensation to the patient of being more voluminous and heavier, but all these phenomena disappear in forty-eight hours, and in ten days the cure is complete. No relapse has been witnessed.

The same treatment is applicable to cysts of the cord. In more than one case where the liquid was not abundant as in children, the preliminary operation of withdrawing a small amount was neglected, and where on the other hand the hydrocele was voluminous (men) a full syringe was injected. Of twenty cases thus treated all were cured in the space of ten or twelve days. One of these cases, however, caused some anxiety. Twenty hours after the operation the patient was seized with rigor, quick pulse, high temperature, while the scrotum was enormously swollen and of violent red. This condition lasted forty-eight hours, but gradually the symptoms subsided, and four weeks afterwards the patient could be pronounced cured.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, April 21st, 1900.

RUPTURE OF INTERNAL CAROTID.

At the "Gesellschaft der Aerzte" Karplus demonstrated from a preparation a ruptured internal carotid. The patient was a female, æt. 65 at death. She was first attacked with pain in the left side of the face, rushing in the ears, ptosis, exophthalmos, pareses of abduccens, as well as the external branches of the oculomotor on the left side of the face. In addition to these symptoms there was great pain in the head and double

vision. Behind the left ear there was a loud systolic murmur disappearing with pressure on the internal carotid artery. All the symptoms pointed to a ruptured aneurism on the internal carotid. After the diagnosis it was resolved to tie the left common carotid artery, this instantly relieved the headache.

Eight days later left hemiplegia occurred which was rapidly followed by lobular pneumonia and death.

TONOMETER AND SPHYGMO-MANOMETER.

Kornfeld brought before the Society a few experiments which he had worked out between Gärtner's tonometer and Basch's sphygmo-manometer wherein he proved that out of 120 cases experimented on only 18 cases were approximately near! The tonometer was generally 5 to 60 per cent. above the sphygmo-manometer.

From these results he thought very little practical good could be obtained from the blood pressure by these instruments. The venous circulation was equally erroneous. The tonometer was too sensitive to muscular pressure, heat, &c., to be accurate.

Gärtner referred to publications of his own which proved manometer experiments to coincide exactly with his tonometers.

TREATMENT OF PHTHISIS.

The treatment of phthisis has recently resulted in the rational use of creosote, but Dr. Pollak recommends duotal which contains 5.5 per cent. of pure guaiacol chemically combined with carbonic acid. It forms a white crystalline powder, has no taste or smell, and is insoluble in cold or warm water. It is given in half gramme doses in the form of an oblate, which may be increased in the course of a few days to 1.5 grammes, or even 4.0 grammes. After 14 days use of the drug the body weight in every case increased 1.4 to 1.6 kilogrammes.

THE CAUSE OF PARTURITION.

Thenen next followed with a long paper on the cause of parturition, as many others who have gone before him, in order to demonstrate that the foetal circulation is confined to the placenta; that the increased embryo demands more nutrition, which induces a degeneration in the shaggy connection between mother and placenta, causing a fracture, as it were, compelling the uterus to act in obedience to the general law of expelling foreign or offending bodies from all of the contractile cavities. Other causes will bring about similar results, as changes in the uterus or embryonic membranes, bleeding, fever, &c. All of them inducing a separation by loosening the shaggy connection.

EPICARIN: A NEW THERAPEUTIC IN SKIN DISEASES.

Kaposi has been using epicarin of late in his wards with apparently good results according to reports. This drug is obtained from creosolic acid and beta-naphthol, and is quite free from the dangerous properties of a caustic alkaline phenolate of naphthol. It is a yellow coloured powder, free from irritating and toxic effects. It acts on the epidemic layer as a "mortifying" agent sometimes accompanied by a slight exudation from cuticular vessels. He has used it with advantage in scabies and dermato-mycosis. In scabies he finds it is best applied in the form of a ten per cent. ointment, which when gradually increased relieves the itching wonderfully.

In prurigo epicarin is rapid in its action in relieving the patient, and has cured cases in ten applications. The ointment is preferable in these cases, and may be

applied to children even when suffering from albuminuria or any other grave complications.

In herpes tonsurans he prefers a ten or fifteen per cent. alcoholic lotion, although he frequently uses the ten per cent. ointment with equally good results.

His recipes are:—

R Epicarin 10 grams;
Ung simplicis 100 grams;

Sig.—The ointment for scabies, eczema, squamosa, &c., &c.

R Epicarin 10 grams;
Spt. vini gallici 100 grams;
„ lavandulae 25 grams
Glycerine 10 grams.

Sig.—To be painted over the parts.

The Operating Theatres.

GORDON HOSPITAL FOR FISTULA.

OPERATION FOR APPENDICITIS.—MR. BOWREMAN JESSETT operated on a man, æt. 24, who had been admitted suffering from pain over the ileo-cæcal region. Three months before he had been laid up with an acute attack of appendicitis, during which he was confined to bed for some weeks, but ultimately made a good recovery. Nine years previously when at school he remembered having a somewhat similar attack, and again some three years later. At the time of admission he complained of slight pain similar to that which had ushered in his last bad attack of appendicitis. He was suffering from nausea, and slight vomiting. On examination of the abdomen some very slight fulness was perceptible over the ileo-cæcal region accompanied by slight tenderness, otherwise there was nothing to indicate any grave mischief. Taking, however, the history of the case, and the present symptoms, Mr. Jessett advised him to have the appendix removed. At the operation an incision was made over McBurney's spot, the peritoneum was opened, and the cæcum withdrawn, when a very unusual state of things was found. The appendix was somewhat large, and was invaginated into a foramen caused by the peritoneum being reflected off the cæcum and joining the meso-cæcum. At the mouth of this foramen the appendix was constricted, but was readily withdrawn; it was very long, being at least three inches in length. The end was bulbous and somewhat injected, and it was also closely bound to the cæcum for some inch and a half of its length by a very short meso-appendix; this last was ligatured and divided and the appendix set free. The peritoneum round the appendix was next snipped round and reflected, fine silk ligature applied and the appendix removed. The peritoneum was stitched over the stump and buried into the cæcum, a few Lembert's sutures fastening the cæcal peritoneum over the stump. The external abdominal wound was closed in the usual manner, three buried sutures of chromic gut being used to unite the fascia and the muscular tissues, silk-worm gut being adopted for the closure of the wound itself. On opening the appendix numerous ulcerated patches were discovered, and some faecal deposits were found at the extreme e. d. Mr. Jessett said that this case illustrated well the importance of advising removal of the appendix in cases of recurrent appendicitis, as, had the case been left alone, disaster must have followed at some future date. He pointed out the unusual condition

of things found at the operation, and said he never had seen a case previously in which the appendix was invaginated through a foramen caused by reflection of the peritoneum as found in this case. In removing the appendix the method of reflecting the peritoneum from the appendix and before removal applying a ligature to the muscular coats, stitching the peritoneum over the stump, and then burying the whole into the cæcum itself was the plan he had adopted now for some years with much success. In closing the wound buried chromic gut sutures were employed, but Mr. Jessett pointed out that as a rule he was not in favour of buried sutures as they often gave rise to abscess and trouble afterwards, but he had employed them in this case owing to the man's occupation, as he thought it might help to prevent weakness of the abdominal wall at a future date.

A fortnight after operation the patient was progressing favourably.

CANCER HOSPITAL.

OPERATION FOR PROLAPSE AFTER TRANS-SACRAL EXCISION.—Mr. CHARLES RYALL operated on a woman, æt. 36, who had been admitted suffering from proclitientia. Two-and-a-half years previously the lower five inches of the rectum had been removed for malignant disease. The operation then performed was that by the trans-sacral route, which necessitated removal of the coccyx and of the two lower pieces of the sacrum, the new anus was formed below the remaining portion of the sacrum. The patient made an excellent recovery, and having been supplied with a plug to keep the motions under control, she was discharged from hospital. Since then she had gained in health and strength, and has been earning her own living in domestic service. About three months after operation the prolapse first began to trouble her. This has steadily increased, and the sacral plug fails to keep it back. Apart from the constant discharge of mucus, she has suffered considerable pain, therefore she was readmitted into hospital for operation. On examination there was no evidence of any local recurrence of the disease, or of any metastatic deposit elsewhere. The prolapsed part, which included the whole thickness of the bowel, appeared about the size of a clenched fist, which could be readily increased by traction on the part, or by the patient straining. An incision was made around and close to the artificial anus, and the anus and bowel carefully separated from the surrounding structures. It was then found that part of the prolapsed bowel was covered with peritoneum, so the serous membrane was opened and the bowel completely freed in its prolapsed part. The peritoneum was then closed; the part of the bowel which had been prolapsed was excised, and the remaining part stitched to the skin in the situation of the artificial anus, so as to form an artificial anus in the old position below the sacrum. The wound having been dressed the patient was returned to bed.

Mr. Ryall said that it was a very satisfactory case, inasmuch as the woman had had the radical operation for cancer performed two-and-a-half years ago, and was still apparently free from disease. The malignant growth was an exceedingly extensive one, so much so, that he had hesitated before operating. The patient was then very emaciated and run down in health, but after excision she made an excellent recovery, rapidly

gaining in weight, health, and strength. He had chosen the trans-sacral operation because it was evidently impossible to get at the extensive disease by any other method; besides, he preferred the dorsal to the perineal operation in all cases of excision of the rectum, first of all because of the ease in exposing the rectum without working in the dark; secondly, on account of the lesser amount of hæmorrhage; thirdly, because it is possible to separate and bring down the bowel without exercising the tension which is unavoidable in perineal excision; fourthly, because the surgeon is able to remove growths which, owing to their extent or position in the upper part of the rectum, it would be quite impossible to extirpate by the perineal route. In the second operation for the prolapse he had dealt with the peritoneum by closing it before incising the bowel so as to avoid infection. The patient with a new plug would now, he said, have a serviceable anus, and be able to keep her motions under control.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, APRIL 25, 1900.

MINOR AILMENTS.

THE facts of modern medicine cover so wide a field that it is impossible for any one man to gather them together in his own grasp, and specialisation has become a latter-day necessity. Any one of the numerous branches of scientific or applied medicine, such as pathology, therapeutics, ophthalmology, physiology, gynaecology, operative surgery, or dermatology is in itself sufficient to engage the energies of a studious lifetime. The general practitioner, on the other hand, has to make a wise digest of essential principles and of empirical facts so grouped as to afford him a basis of rational investigation and procedure. That is a part of his professional education not taught in the schools, where scientific education is as a rule con-

ducted with little or no regard to the future needs of actual practice. But the lesson has to be learnt by the tyro when he enters the ranks of the profession, and is brought face to face with the complex phases of disease presented to him at the bedside or in the consulting-room. Under such circumstances, perhaps, one of the most perplexing factors is his want of acquaintance with minor ailments. Instead of having to face a number of serious diseases of well-marked type, such as chronic Bright's, cirrhosis of the liver or locomotor ataxy, he is asked for advice for a headache, a cough without physical signs, or a passing insomnia. It may be said that the minor ailments of general practice are for the most part symptomatic, and the power of diagnosing their exact value may be regarded as one of the greatest and highest of professional acquisitions. For the earlier stages of practice the tendency is to ignore this or that trivial pain or discomfort as of no importance, whereas in the day of ripe experience no detail of the kind is without its significance. As an instance in point we may take the vague rheumatic pains of which patients so often complain. They may be the result of auto-inoculation by absorption from the bowel, of toxic invasion, of obscure gout or rheumatism, of commencing central or peripheral nerve trouble, of early osteo-arthritis, or of various other conditions, the recognition of which may be of the utmost importance to the future well-being of the patient. Headache may be the result of hyperæmia or ischæmia, it may be due to eye-strain, to arterial changes in the brain, to meningitic affections, to drugs, alcohol, or toxic invasions, and to other causes which have to be carefully considered. These examples might be multiplied well-nigh indefinitely, but they will serve to illustrate the necessity of unremitting care and vigilance on the part of all who follow one of the most responsible of all the professions. In a certain sense the class of minor maladies is so small as to be non-existent, that is to say, if we regard them as self-contained, specific morbid processes. A fairly perfect example may be found in chloasma, the fawn-coloured patches due to invasion of the skin, by the *microsporon furfur*, but even then the constitution of the patient apparently has a considerable predisposing and modifying influence. Indeed, it may be said that isolated minor maladies are rare. Their special importance is in the initial stages of disease as for instance in early tuberculous, kidney, mental or cord disease. In each of those conditions the carefully educated eye can discern signs and symptoms that are hidden to the tyro. It is precisely in the first stages that most hope lies in the efforts of curative medicine. The middle and later stages of chronic disease, while they are more readily recognised, represent pathological changes that are beyond the control of therapeutic measures. One of the most valuable means of medical education under the now abandoned apprenticeship system was the imparting of the subtle knowledge of minor maladies imparted from the ripe experiences of older men. Nowadays, the individual practitioner has to seek compensation for that particular advantage by a close study of the

recorded experiences of others, and by the painstaking accumulation and comparison of facts that have come within the range of his own observation.

THE PROPHYLAXIS OF INEBRIETY.

WE can understand and appreciate the sentiments which influence such men as Sir Wilfrid Lawson, the Archbishop of Canterbury, and many others when they feel deeply the injuries done by those who indulge in alcoholic excesses, and when they see no way to prevent them, except by practising total abstinence, and by strongly advocating it. It must be admitted that we cannot find support for the principle of total abstinence in the religious doctrines of these times, for St. Paul advised his great intimate Timothy, to "drink no longer water, but use a little wine for thy stomach's sake, and thine often infirmities." If we observe the characters of those who suffer as inebriates, we see that they differ as much from one another in their intellectual and moral natures as ordinary individuals do. Some, there is no doubt, could not be indifferent to the self-denial and devotion of a friend or relative who would agree to total abstinence for no other reason but to be in sympathy with the sufferer, but some, and we fear the majority of inebriates would not be influenced by such self-sacrifice. The question that is coming up now is really what is the proper course to pursue, religiously, morally, and legally in the management of inebriates; as well as in the control of tendencies to too great indulgence among all classes of the people. We think that none are so well able to direct in such a question as those members of the profession who can assess fairly the extent to which intemperance ought to be treated as a disease; and feel sure that fasting, or prayers, or severe punishment cannot possibly restrain or diminish. When we see in any nation too great indulgence practised in any habit, such as drinking, whether tea, coffee, or alcohol, or in the abuse of opium or other narcotic, we may be sure that certain unhealthy conditions have been the cause of the vicious practice. What may have caused the conditions it may be difficult to discover, though we fear that the difficulty is not so great as the desire to avoid it as much as possible. If a man or woman at any time can be honestly certified by a qualified practitioner to be in a condition of mind or body such as to render him or her unconscious of their actions and legally irresponsible for them, there would be no difficulty in giving such powers to others as would enable them to control the patient and prevent recurrence of the attacks. There is no doubt but that the best plan of dealing with those who cannot refrain from excess in alcohol is to keep it entirely out of their power to get at it, much in the same way as we are careful not to let a cat be left with a canary. But the same might be said of tobacco or opium, or any other agent which is dangerous when taken in excess. If, for the sake of the few who cannot control themselves and will commit excess, we are to deprive all of the undoubted benefits of any agent that Nature, or Art may have

supplied us with, we may really be doing more harm than good. "Poison heals in just proportion given," while everything given in unjust proportion may be regarded as a poison. It would be well now for the profession to consider carefully how to advise the Legislature to make laws to prevent excess and trouble. There is one method which occurs to us as deserving of serious consideration. We take the view that there is a great advantage in using fermented liquids such as wine and beer for common consumption; but when the alcohol they contain is separated from them, and this is allowed to be used with the same freedom as is permitted for the fluids from which it is distilled, we may fairly question the wisdom of this. In the process of fermentation it is not possible to obtain more than a small proportion of alcohol, so that the best beer of this and other countries, and the best wines cannot produce more than from the three to fifteen per cent. of alcohol. The common beer produces less than three per cent., and it seems to us very reasonable to make laws for alcohol different from those applying to various kinds of fermented fluid. From a medical point of view we think there is no necessity to separate the alcohol by distillation, and that special laws should be passed to control the use of alcohol. If alcohol could be placed in the same class as opium and many other poisons—that is to say, under the control of the profession—it would be of public advantage, and much of the trouble that now comes from its abuse would be avoided. We leave this proposal to the consideration of our readers, and hope that they will give it their serious attention.

Notes on Current Topics.

Sleeplessness.

INABILITY to sleep is a symptom of a very variable significance, but in the majority of instances it is a functional disturbance due to some part of the vital mechanism being out of gear. Before permitting himself to prescribe hypnotics, the physician ought always to inquire carefully into the habits of the sufferer with the object of discovering a reasonable explanation of the condition, and of remedying it without the intervention of drugs, which are, therapeutically speaking, at best but a *pis aller*. The cause will often be found in a disturbance of the digestive or nervous system. It is especially important in this regard to secure a suitable interval between the evening meal and retiring to rest. The stomach should be neither empty nor engaged in the process of active digestion. Persons who take a late dinner ought not to retire to rest for at least four hours, while if the period be protracted much beyond this a biscuit, a glass of milk or other unsubstantial nourishment may be taken with advantage. It is surprising what effect on the ability to sleep is produced by inattention to this simple detail. Persons whose digestion is laborious ought either to abstain from a full meal late in the day or they should make a point of taking a moderate amount of gentle exercise,

such as a walk in the open air, before going to bed. Apart from worry and business preoccupations nothing produces such a markedly deterrent effect on sleep as tobacco, especially if smoked right up to the time for going to bed. Tobacco insomnia is peculiar in that it does not necessarily prevent the person falling asleep, but it tends to render sleep preternaturally light, and therefore unduly liable to disturbance; and, in excess, tobacco causes early awakening, leaving the sufferer in a condition of irritable insomnia fatal even to physical quiescence. The simple precaution of restricting the number of cigars smoked during the period immediately preceding the hour of repose will often suffice to secure satisfactory sleep. Another point not without its importance is to avoid active mental exertion late in the evening without an interval to allow the cerebral circulation to quiet down.

Prevalent Diseases in the Philippines.

THE American occupation of the Philippine Archipelago has drawn attention to the diseases prevalent therein, especially so, inasmuch as a statement was recently made that American soldiers, engaged in the occupation, were dying at the rate of one thousand a month. However, this statement has since been refuted, and proved to be entirely erroneous. In this connection some interest attaches to the report of a committee appointed to investigate the prevalent diseases at the Philippines by the Johns Hopkins University Medical School, which has just been published in the *Bulletin* of that institution. The report deals with the diseases mainly affecting the natives and those affecting the Americans. In the former case small-pox is by far the most frequent, and its prevalence is clearly shown to be due to the neglect of vaccination. Among the American land forces, on the other hand, the most common diseases were found to be diarrhoea, dysentery, typhoid fever, and gastro-intestinal catarrh. Malarial fever, again, was not infrequent, but it was only responsible for a very few deaths. A curious form of disease was that described as "tropical ulcers"—an indolent form of ulceration of the skin. The ulcers occurred sometimes singly, but they were more often multiple, being more frequent among the soldiers who had been compelled to make long marches through swampy districts. The men attributed the disease to "poisoning" in the marshes, and this may have been the case, seeing that it began in the form of small pustules, which gradually extended to ulcers. Pulmonary tuberculosis was by no means uncommon among the American troops, this being attributed to exposure to wet and the various hardships inseparably associated with the campaign. The report adds that the climate of the Philippines from November to March is delightful, while the extremes of temperature are not great throughout the year, though the constancy of the high temperature, together with a high degree of humidity, make the climate peculiarly enervating. In the worst season of the year the climate is so trying that Americans will not be able

to maintain their health unless certain special precautions are taken.

The Vacant Parliamentary Representation of Edinburgh and St. Andrews Universities.

THE recent death of Sir William Priestley, M.P., renders the parliamentary representation of the Universities of Edinburgh and St. Andrews vacant, and the Unionists in the constituency have already decided upon a candidate to succeed the late member, in the person of Sir John Batty Tuke. It is not at all probable that his election will be opposed. Should he be successful he will be the second medical man in succession who has filled the post; in contrast to a previous series of three members of the legal profession who were also Crown officials, and all of whom now occupy seats on the Scottish Judicial Bench. Antecedent to these the Universities were represented at Westminster by the late Lord, then Sir Lyon, Playfair. The election of Sir William Priestley was especially notable in that it broke the succession of Crown lawyers who could always (if of Conservative or Unionist conviction) be found a safe seat, even if their sympathies were ill-attuned to academical themes; while the great preponderance of medical graduates in the electorate merited, occasionally at least, the return of one of their own calling. Sir John Batty Tuke, who has had no inconsiderable experience of duties which should assist him at Westminster, both as President of the Royal College of Physicians of Edinburgh and as a member of the General Medical Council, devoted himself primarily to the care and treatment of the insane, and his name is widely known from his writings upon this subject. But his labours have by no means been confined to this branch of medicine; much of his time has been given to work directed towards the general good and well-being of the profession, and his efforts in this way have often borne valuable fruits. A man of broad mind, full of concern for all matters connected with academical institutions and management, ready to speak out his thoughts, however conflicting they may be with those of others, his election, if carried, will certainly strengthen the hands of the medical profession in the House of Commons, and even if he should form one of the more silent members, he is sure to work hard in other ways, and to achieve as much as is possible in the interests of science, education, and medicine.

Causes of Lunacy.

THIS subject has been discussed, curiously, under the auspices of the Saltley Liberal Association, by Mr. Osler, who has evidently taken a very prominent part in the doings of the association. He seems to think a great deal too much money is spent on asylum buildings, and perhaps he is right. One very curious remark of his was that the "hire system" is probably responsible for a good deal of lunacy. He informs us that a man who ought to know what he was saying told him that there were at least 40,000 men in Birmingham who had not the fee-simple of their own bodies—they had bought things on the hire system

and were liable to be taken to prison if their payments were not kept up. That must surely add greatly to the anxieties of life, and anxiety no doubt was one of the great causes of lunacy. He makes one very shrewd remark regarding the management of public boards, which would be of interest to medical men who attend officially at such meetings. He stated that he was told by a very shrewd old member of the council that if one wanted to get a difficult vote through, the best thing was to put down early on the agenda something, say, about moving a cabstand, a measure which every member had an opinion upon, and was well able to understand. When that had been debated hotly for two or three hours, and the council was tired, then you could get almost anything through. His remarks on the subject of the cost of asylum buildings are well worthy of notice. Thus, he observes, that a large number of whole families of Birmingham lived in houses which perhaps cost £200, whereas the cost of each bed in a new asylum would be probably £400. As regards the causes of insanity, except what he has said about the "hire system," there is nothing new, but undoubtedly anxiety, worry, and care, have their own share in the production of insanity, especially because they often lead to intemperance.

Alcohol and Infantile Mortality.

THE terrible infantile mortality in Great Britain may well give pause to those who are inclined to boast of the results of modern preventive medicine. It is the result of many causes, direct and indirect, such as poverty, overcrowding, insanitary environment, but most of all to the improper feeding of infants. The relation of alcohol to the lamentable loss of life in this direction has never been recognised, in the opinion of not a few medical authorities, to anything like the extent it deserves. Among poor, ignorant parents, there can be no doubt that the practice of dosing babies with alcohol is practised far and wide in a way that is simply appalling. With older children it often happens that when sent to public-houses for a supply of liquor they help themselves to some of the pernicious stuff upon the road home. It is hardly necessary to remark that from a medical point of view it would be difficult to imagine a more insidious and dangerous poison for infants and children than alcohol. This point was illustrated last week before a London coroner, who was called upon to investigate the circumstances attending the death of a boy four years old. The unfortunate child appears to have gone downstairs and swallowed part of a quartern of whiskey that had been left out in the kitchen. Symptoms of acute alcoholism soon developed, and death ensued after a couple of epileptiform seizures. The action of alcohol as an irritant, direct and indirect, can be well observed in such cases and deserves careful attention at the hands of the medical profession. A point worthy of careful investigation is the excretion of alcohol through the breast of the suckling mother. Some precise data upon this subject would enable one to formulate a working rule in practice as to the

desirability or otherwise of allowing a mother to take alcohol when in such a condition.

Hypnotism in Medicine.

THERE are strong indications of the revival of the hypnotism craze in medicine. From many points of view it is desirable that any movement of the kind should be followed with close attention, both in the interests of the public and also of the profession. It is hardly necessary to remind readers that ever since its appearance on the stage of worldly affairs hypnotism has been made the tool of many gross frauds. Not long since, one of the most distinguished French authorities on nervous disease, since dead, discovered that he had been made the victim of the most transparent frauds on the part of so-called mediums. From America, telegrams have been published containing sensational statements as to certain alleged feats of hypnotic surgery. During the birth of an infant, the mother was rendered insensible to pain by the process of hypnotic suggestion, which state continued through a subsequent "difficult surgical operation." The mother is reported to have slept through all this period of stress and trouble "without even an expression of pain passing over her face." For all that, it may be predicted with a tolerable degree of confidence that hypnotism is not likely to replace chloroform in assuaging either the pangs of labour or the pain of surgical operation. At the best special qualities are needed not only on the part of the operator but also of the subject, before the desired hypnotic condition can be obtained. For the present, the attitude of the medical profession towards hypnotism will be one of expectancy, to a great extent tinged by a caution begotten of the memory of past experiences.

The Diathetic Factor in Diagnosis.

THE fact that manifold symptomatic phenomena may be set up by one and in the same agency acting upon different individuals has long been a perplexing point in the study of disease. Why, for instance, should one patient suffer in his muscles, another in his joints, another in his nervous system another in his heart, when the disturbing morbid process in all is rheumatic poison? The convenient cloaks for ignorance beneath which we take refuge are expressed in such vague general terms as "dyscrasia," "idiosyncrasy," or "diathesis." It is all very well for the logical investigator to quarrel with such descriptions, and to assert that by using them we merely shirk the difficulty. There can be no doubt that they express the marked predisposing agency of inherited susceptibility in certain directions, and towards certain types of disease. In our present state of knowledge it may be freely conceded that much has to be learned before the various forms of diathesis can be classified so as to carry the full weight and precision to which they are probably entitled. To understand the constitution has long been the privilege of the old family doctor, and the phrase conveniently expresses the general truth which is embodied in the care with which any systematic medical

investigator looks after the family and the previous history of a patient. A capital essay might be written by a really well educated and experienced general practitioner upon the subject of "The Inherent Debility of Tissue, or the Diathetic Factor in Diagnosis."

The Vertebral Complications of Typhoid Fever.

THE complications and sequelæ of typhoid fever, as enumerated in the text-books, are already extremely numerous, and further observation tends to add to their number. Dr. Quincke, of Kiel, in common with several other German physicians, has recently called attention to certain lesions of the vertebral column which have been observed to accompany or follow attacks of typhoid fever, of the nature of spondylitis. The symptoms, which may be delayed for some weeks after apparent recovery from the original disease, commence with severe pain in the lumbar region of the spinal column associated with a rise of temperature, the least movement of the trunk or pressure upon the spinous processes of the affected area giving rise to intense suffering. More or less pronounced paresis of the lower limbs follows, associated, in some instances, by shooting pain running down to the toes. The patellar reflexes are reduced and ultimately lost, and there may be passing incontinence of urine and feces. In several instances definite tumefaction was observed over the region of the spinal column attacked, but the prognosis so far appears to be invariably favourable, a fact which renders it important, from the point of view of prognosis, to distinguish this spondylitis from the tuberculous form. The special diagnostic point is the suddenness of onset which contrasts with the insidious commencement of Pott's disease, for example, and its nature may be suspected when there is a history of a recent attack of typhoid fever, confirmed by Widal's reaction which, as is well known, continues for a tolerably long period after the disappearance of the enteric symptoms. The treatment is limited to immobilisation by means of a suitable apparatus, and the administration of analgesics to relieve the painful manifestations.

Artificial Legs.

A GREAT impetus has been given to the surgical appliance trade by the war in South Africa. As the result of generations of mechanical evolution, the artificial leg of the present day has become a perfect marvel of skilled workmanship. The essentials of such a limb are somewhat hard to satisfy. Lightness is, of course, a vital point, the attainment of which was long since achieved by the use of cork. Another chief requisite, a quick, smooth action of the joints in response to the pressure of the toes upon the ground, however, at once takes us into a most complicated mechanical field. It is impossible to enter into detail here, but it may be stated briefly that the natural movements are now imitated in a simply marvellous fashion, so that workmen are able to engage in occupations that would seem to be out of the reach

of anyone minus one of his legs. To ride a bicycle with a modern up-to-date artificial leg is regarded as quite an ordinary feat. One of the most difficult things to prevent is noise, but that is altogether absent in the best modern productions. Clearly, it is just as undesirable that a man should noise abroad the history of his bodily bereavement by means of rattling springs, as it was in the old days by the thumping of the once familiar wooden leg. The instrument maker of to day is a mechanist of the highest skill, who presses every advance of technical science and art into his service. One of his latest feats has been to make a leg that will move quickly in walking, but will take a natural position of rest when the owner sits down. Such an appliance can be procured at the extremely moderate price of three or four guineas.

A Novel Appointment at Cardiff.

THE management of the Cardiff Infirmary appears to be determined to keep the affairs of that charity before the public. Last week there was a considerable breeze raised by the extremely irregular appointment of a resident medical officer. It appears that the post has been advertised for several months past, only recently had any applications been sent in, presumably on account of the number of medical men who had gone to the war. In accordance with the usual rule one of the candidates was chosen by the Medical Board for recommendation to the Committee. Before the latter met to make the appointment, however, the gentleman selected wrote to ask if he had been appointed, to which question the chairman took upon himself to answer in the affirmative. This action was clearly out of order, and was very properly made the subject of a prolonged discussion when the committee was asked to approve the appointment. If such high-handed procedures were permitted the door would be at once opened for all kinds of jobbery in these posts, for which as a general rule the competition is keen. The Chairman of the Cardiff Infirmary Committee freely admitted that the responsibility he had undertaken was not in accordance with the rules, and the appointment was finally approved. It is somewhat surprising that the Chairman, as a retired soldier, should have acted so irregularly, and it is not easy to understand why he should have received the support of the medical board in attempting to enforce so dangerous a precedent.

Typhoid and Bleeding.

AN amusing discussion took place a few days since at the meeting of a north country District Board in reference to the serum diagnosis of typhoid fever, which is reported in the local newspapers under the above fallacious title. The discussion arose on a proposal made by the Medical Officer of Health to provide the neighbouring practitioners with the necessary apparatus for carrying out Widal's sero-test for typhoid fever. The mere mention of the fact that the process entailed the withdrawal of a drop of blood for the purpose of bacterial examina-

tion raised a storm of protest, and it was confidently asserted that no patient would submit to being "bled" merely in order to gratify "doctors' curiosity." Another argument urged against routine resort to the test was the trifling delay which would be caused in the transport of the sufferer to an isolation hospital. It does not seem to have occurred to the speakers that a delay of twenty-four hours in the isolation of a patient suspected to be suffering from typhoid fever is of small importance compared with the risk which a mistaken diagnosis would entail in the not inconsiderable proportion of cases in which the disease proves to be something other than typhoid. Ultimately the suggestion was agreed to on the understanding that should the doctor decline to be saddled with the trouble of confirming his diagnosis, or should the patient refuse to be "bled," no opposition would in either event be offered to the reception of the patient.

The Dustbin.

WITH the approach of warmer weather the perennial dustbin cannot fail shortly to attract attention, as has always been the case since the institution of this unhygienic horror. The apathy of municipal authorities towards this relic of the, from a sanitary point of view, Dark Ages, is really remarkable. Hundreds of thousands of pounds are spent annually on measures intended to circumscribe the ravages of disease yet this olfactory abomination is tolerated, for all the world as if it represented the latest and most perfect means of disposing of organic *débris*. True, the daily and compulsory removal of rubbish would entail some additional expense, but prevention is admittedly better and more economical than cure, and the increased expenditure in one direction would doubtless be more than compensated by a reduction in other departments. Under existing arrangements it is idle to expect even a moderate regard for the most elementary laws of hygiene on the part of servants, and the evil effects of negligence are accentuated in towns by the growing tendency to live in flats whereby the emanations are brought under the noses of the myriad occupiers *en bloc*. There is still no sign, at any rate in London, of any intention to reform this long-standing abuse, and our only resource is to seek to educate the public in the importance of the interests at stake.

Appendicular Pleurisy.

UNDER this title Professor Dieulafoy calls attention to the frequency of pleural infection in connection with appendicitis, a frequency which appears to be more marked than is generally suspected. He ascribes the complication to direct infection of the pleura through the lymphatics, and this view concords with what is known of the essentially infective nature of the appendicular lesion. It usually makes its appearance between the eighth and fifteenth day after the onset of the appendicitis, it is as apt to occur in the mild as in the severe cases, and it is usually the right pleura which is the seat of the secondary infection, the initial symptoms of the

pleurisy being masked by hepatophrenic symptoms, this being the path by which the infection travels. Perforation, with consequent pneumothorax, is a not infrequent result, with corresponding aggravation of the constitutional symptoms. The possibility of this grave complication will strengthen the hands of those who are for immediate operation in all well-marked cases of appendicitis, since the removal of the focus of infection in the appendix not only spares the patient the risks associated with its presence in the abdominal cavity, but also saves him from the further risk of secondary infections elsewhere.

The Royal London Ophthalmic Hospital.

THE announcement that the Committee of Management of the Royal London Ophthalmic Hospital have decided to add to the staff of the institution by electing three more assistant surgeons is likely to cause a flutter of excitement among the younger ophthalmic surgeons in the metropolis. On the other hand the decision is one which can be warmly commended, while the only wounder is that the change was not carried out long before. As a matter of fact, the amount of work to be done at the institution has for many years been much greater than the existing staff has been able to accomplish without extreme pressure. Moreover, the work must have inordinately increased since the School Board for London has undertaken to refer the children suffering from defective sight to the various hospitals. Under the circumstances, therefore, the Committee of management of the Ophthalmic Hospital have probably found that it was absolutely necessary to increase their staff in order to meet the augmented demands upon the services of the institution. It will be remembered that the hospital is now located in the City Road, and this being the case, we presume that the former name applied to it, namely "Moorfields," will cease to be used. At all events the term cannot now be said to have any significance.

Overfeeding and Underfeeding.

A LAY contemporary makes merry over the apparent contradiction between the allegation of overfeeding, which is the basis of Dr. G. S. Keith's instructive little monograph "A Plea for a Simpler Life," and the hyperalimentation advocated by certain authorities on the treatment of pulmonary tuberculosis. Obviously the contradiction is more apparent than real. One author discusses a *régime* for the healthy while the others deal with a *régime* suitable for the sick. It is possible—nay, probable—that overfeeding is the rule in a certain class of contemporaneous society, and the pampered ones sooner or later suffer the pangs and penalties attendant upon habitual gluttony. By far the larger number of the inhabitants of this happy isle, however, are more liable to suffer from under- than from over-feeding, consequently when they develop such a disease as tuberculosis, which is essentially a disease of undernutrition, quite irrespective of the amount of food eaten, hyperalimentation is likely to give good results, provided always that the digestive apparatus of the sufferer

is yet, or can be brought into a condition, capable of dealing with the material to be assimilated.

Election of Coroner for Dublin.

A SPECIAL meeting of the Municipal Council was held on the 19th for the purpose of electing a City Coroner. Twelve candidates sought the appointment, about half being medical men, the remainder being members of the legal profession. The election was by ballot, the first round resulted in qualifying three medical candidates, namely, Dr. R. D. Kenny with 17 votes, Dr. Louis A. Byrne 16, and Dr. T. O. C. Redmond 10 votes, the rest not having polled the requisite number were disqualified. The second voting showed nearly similar proportions, and only the first two candidates were left in for the final vote, when Dr. Byrne received 33 votes and Dr. Kenny 26. The Lord Mayor thereupon declared Dr. Byrne duly elected to fill the post. Dr. Louis A. Byrne is one of the medical staff of Jervis Street Hospital and Medical Officer of the High Street Dispensary—neither of which positions does he necessarily vacate. He also enjoys a considerable private practice in that district.

The Scottish Asylums' Pathological Laboratory,

WE have on previous occasions directed attention to the splendid work which is being done by the Scottish asylums in pathological research in their Edinburgh laboratory under the directorship of Dr. Ford Robertson, who has made considerable advance recently in microscopic work, and particularly with his new staining methods. The one drawback is want of funds. Dr. Robertson, in his latest report, shows how necessary it is to extend the laboratory, and to have a chemical department under a chemical authority. Of course, bacteriological work will some day follow, for this is no less necessary, and here is an excellent opportunity for men who can afford to endow scientific research, and who, in doing so in this instance, will promote the knowledge of the pathological work of one of the most terrible diseases to which humanity is subject. We specially commend the claims of Dr. Ford Robertson's scheme for extending his laboratory to the profession in Scotland especially.

The Royal Visit and the Fellowship R.C.S.I.

IN recognition of the Royal visit, the Council of the Royal College of Surgeons, Ireland, has resolved to grant the Primary Fellowship Examination to all students of the College who pass the Second Professional Examination on or before July 31st, 1900, on fulfilling the other necessary conditions. This resolution applies to licentiates, whether under or over ten years' standing, and to all students who pass the Second Professional Examination for the conjoint Diploma of the two Royal Colleges. The Second Professional Examination and the Examination in Physiology must be completed. We are requested to notify that all persons wishing to obtain the benefit of this resolution must claim the benefit before July 31st, 1900.

The Victoria Cross.

IT affords us much pleasure to announce that her Majesty the Queen has signified her intention to confer the Victoria Cross on Surgeon-Major William Babbie, C.M.G., Royal Army Medical Corps. At Colenso, on December 15th last, the wounded of the 14th and 66th Batteries Royal Field Artillery were lying in an advanced donga close in the rear of the guns without any medical officer to attend to them and when a message was sent back asking for assistance Major Babbie rode up under heavy rifle fire, his pony being hit three times. When he arrived at the donga where the wounded were lying in sheltered corners he attended to them all, going from place to place exposed to the heavy rifle fire which greeted anyone who showed himself. Later on in the day Major Babbie went out with Captain Congreve to bring in Lieutenant Roberts, who was lying wounded on the veldt. This was also under heavy fire.

The Plague Riots at Cawnpore.

ANOTHER serious outbreak of rioting in connection with the enforcement of sanitary precautions against the spread of plague has just occurred at Cawnpore, and although a semblance of order has been restored by the interposition of the military, the population still preserves a sullen attitude. This fanatical opposition is one of the difficulties which confront the sanitary reformer in India, and its possibility has always to be reckoned with. It is not for us to criticise those who are entrusted with the onerous task of checking the spread of a filth-begotten and deadly disease in uncongenial surroundings, but we usually find on inquiry that there has been a want of tact in dealing with an ignorant and superstitious populace who resent being violently constrained to adopt certain desirable but, to them, objectionable precautions.

THE ridiculous muzzling order has been withdrawn in the County and City of Dublin, and in the Counties of Galway and Mayo and the King's Co. It was always a totally unnecessary infliction upon the dogs, and was based upon ignorance of the facts as to the prevalence of rabies.

DEGREES will be conferred by the University of London in its new home at South Kensington for the first time on the 9th prox., and H.R.H. the Prince of Wales has announced his intention to be present at the ceremony.

THE question of insisting on the use of bottles of readily distinguishable shape for poisons is receiving attention in the Legislature of the New York State.

THE ninth annual meeting of the German Otolological Society will take place at Heidelberg on June 1st and 2nd.

THE vaccination of children has been made compulsory in Constantinople.

A HOSPITAL for the treatment of venereal diseases is shortly to be opened at Jerusalem!

IN all new school buildings in New York provision is being made for shower and plunge baths.

PERSONAL.

DR J. R. SKINNER has been elected Mayor of the Borough of Winchelsea.

DR. A. KINSEY-MORGAN has been elected Coroner for the County-Borough of Bournemouth.

MR. S. STREETTON, M.B.C.S., of Kidderminster, has been appointed a Justice of the Peace for the County of Worcester.

PROF. A. S. GRUNBAUM, of Vienna, claims priority in the discovery of the agglutinating effect of serum on typhoid bacilli, known as Widal's reaction, his claim being based on a certificate signed by Prof. Nothnagel and Dr. Mannoberg.

THE departure of the distinguished Australian surgeon, Sir T. N. Fitzgerald, for the front was the signal for an outburst of enthusiasm at Melbourne. The idea originated with Professor Allen, of Melbourne University, and Dr. Charles Ryan, the Australian hero of Plevna. Sir Thomas Fitzgerald consented at once, declined to accept any payment for his services, and sailed for the Cape with the Victorian Bushmen's Corps in the transport *Euryalus*. It may be mentioned that when a medical student he volunteered as a combatant during the Crimean war, but peace was signed immediately after, and his services were not needed.

Scotland.

[FROM OUR OWN CORRESPONDENT.]

THE CHAIR OF PRACTICE OF PHYSIC AT EDINBURGH.—Great uncertainty exists regarding the date of the election of a new Professor of Medicine in the University of Edinburgh. The list of candidates who finally handed in applications before the final day for doing so consists only of four names—Drs. Wyllie, Byrom Bramwell, James, and Gibson. Of these Dr. Wyllie has abstained from sending in any testimonials, contenting himself with a simple application. Each of the others have presented a formidable array of testimonials to the Curators for their instruction, Dr. Bramwell's collection being especially large. The ultimate result of the election is shrouded in absolute obscurity, and no one seems to have the slightest inkling of how it will eventually turn out. There appears to be some difficulty in arranging for a meeting of the Curators of Patronage at a time when they can all attend, and the importance of the post to be filled by them in connection with the University itself, and with the whole Medical School of Edinburgh, may lead to a postponement even of some weeks or even months, should a full sederunt be unattainable earlier. Dr. Alexander Bruce has meantime been temporarily appointed to perform the duties of Professor of Clinical Medicine, and to read the theses for the M.D. degree until what time the new Professor has been appointed, and has entered upon the work of his office.

EDINBURGH UNIVERSITY GRADUATION CEREMONIAL.—Last week the Spring Graduation ceremonial of this University was carried out. Among the recipients of the honorary degree of LL.D. was C. D. F. Phillips, M.D., LL.D. (Aberd.), of London, who for some years filled the University Assistant Examinership in *Materia Medica* in Edinburgh, and who held for some time a similar post in Glasgow. The degree was conferred on him in recognition of his important researches in pharmacological subjects, and of his personal services to

the University, and is additional to the honorary degree of the same class given him by his alma mater, Aberdeen University, previous to this. The conferring of the LL.D., degree upon a lady was interesting as being the first example of the honorary Doctor of Laws awarded to a woman. Miss E. A. Ormerod, F.R.Inst.Soc., F.E.S., &c., was the worthy recipient, in fitting recognition of her observations into entomological subjects, especially as regards agricultural parasitic scourges. In introducing Miss Ormerod the Dean of the Faculty of Law described her as the "protectress of agriculture and of the fruits of the earth." Professor Anderson Stewart, of Sydney, had the same degree conferred on him *in absentia*. No medical degrees were conferred, excepting on four graduates, who had gained their B.Sc. in Public Health.

GLASGOW UNIVERSITY GRADUATION CEREMONIAL.—Seldom have we seen the Bute Hall on graduation day so thoroughly crowded as it was on the 17th inst. There was a large number of graduates, and among the number no less than 17 female graduates. Although the assemblage was a brilliant one, the same cannot be said of the conduct of the students generally. At the outset of the Principal's address, he was received with stormy and prolonged interruptions from the students generally, but more especially by those at the back of the audience, and a repetition of the scene which took place on his first appearance as Principal, when the proceedings were abruptly and summarily closed, was feared. This time, however, he turned to the students and said: "You have been making a great deal of most unpleasant interruptions since we began; it has had neither wit, nor sense, nor manners to recommend it, and if this is to continue I will simply go no further. I hope we may have silence." This rebuke had the effect of restraining the exhibition of a most vulgar description. With all the advantages at the command of the students at Gilmour Hill the majority seem not to be able to throw aside the habit and expression of vulgarity, notwithstanding the fact that they come into daily contact with teachers and others who are gentlemen. There is no desire to restrain altogether the exuberance of youth, but when it goes beyond legitimate limits it becomes a vulgar nuisance and must be crushed out. The Principal then proceeded with his address without further interruption. He remarked on the many changes that had been taking place both in the University and in the Infirmary (Western). In the former Professor Sir William T. Gairdner had found it necessary on account of bad sight to resign his chair of Practice of Physic, whom he characterised as "a model teacher." In the Western Infirmary, Dr. George Buchanan, for many years Clinical Lecturer on Surgery, had resigned, and his place is to be filled by Dr. Hector Clare Cameron, the latter being succeeded by Dr. Beatson. In applying for and obtaining the Chair of Clinical Surgery, Dr. Cameron had to resign his position as a member of the University Court. From the Royal Infirmary Dr. H. E. Clark had been successful in getting an appointment as surgeon to the Red Cross Medical Corps from Glasgow to the "front," Dr. James Dunlop of "that ilk" having preceded him. For all these nice, and in many instances comfortable billets, only the favoured ones were taken, and in such instances influence works the oracle. It is certainly in accordance with the old saying, "Tis better to be born lucky than rich."

ABERDEEN PARISH COUNCIL.—ELECTION OF TWO MEDICAL OFFICERS.—This Council last week proceeded to choose two medical officers for the City out of nineteen applicants, one of whom was a lady doctor. First ten were voted for, then five of the ten, and of the five a gradual process of exclusion decided the two who should occupy the posts. The variations in the votes polled by the candidates as they passed through the reducing process are most instructive. One of the successful applicants remained at the top throughout; the other equalled his top vote in the first poll, fell to third, then fourth, and third again, before the final result restored him to his first position. That is to say, that one of those appointed polled a smaller number of votes than one of the unsuccessful candidates out of a

list of ten, than two out of five, and one out of four, but gained the post in the end. How uncertain such elections must often be. Drs. Phillips and Watts were the two appointed. The female candidate, we notice, received 16 votes at the first ballot, placing her seventh on the list, and 11 at the second one.

SALE OF PRACTICE.—A DISPUTED CASE.—Dr. John Nairn, of Glasgow, sold his medical practice at Patricroft, Lancashire, to Dr. Spearing for £700, last June; £300 was paid down at once, £220 was to be paid after the expiration of six months, and the remainder at the end of twelve months. At the Assizes in Manchester, last week, Dr. Nairn gained a verdict for the first £200 unpaid by the purchaser of the practice, who alleged that fraudulent representations had been made about it, as it had not come up to his expectations. The fact that so many are willing to pay relatively large amounts for the goodwill of practices, irrespective of what may be the favour bestowed on them in the future by the patients of those who went before, bears witness to the existence of a large degree of short-sighted confidence on their part. A patient is not like goods and chattels, to be bought and sold at will. Personal influences must have some effect in the matter, and to agree to pay a certain sum for a practice with one's eyes unopened to the risk, is no excuse for non-fulfilment of the contract.

MEDICAL SOCIETY OF LONDON.

THE meeting on Monday evening last opened with a paper by Mr. Thomas Bryant on "Cysts of the Breast in Relation to their Frequency, Diagnosis, and Treatment." The paper bore on 242 consecutive cases of breast disease occurring in private practice during the last ten years. The result of his examination was to show (1) that simple cysts of the breast are far more common than they are generally believed to be, (2) that they are chiefly found in women during the same period of life as that in which cancer is met with, (3) that they are mostly quite amenable to treatment without the sacrifice of the breast gland in which they are situated, and (4) that there is no reason to believe that women who have these cysts are more prone to cancer than others who have them not. After eliminating twelve cases which had no bearing on the question of diagnosis there were 163 which had been diagnosed as cancerous or sarcomatous to 67 of diagnosed cystic disease, so that of every four cases of breast disease simulating cancer, one would prove to be an example of cyst disease.

Dr. Steele Perkins mentioned two cases showing how even very able men could make mistakes in the diagnosis of breast tumours, two eminent surgeons having diagnosed as cancerous, tumours which proved on incision to be abscesses.

Dr. Campbell Pope remarked that general practitioners saw these cases in their early stage when the difficulty of arriving at a diagnosis was often very great. He himself attached most importance to dimpling of the skin as pointing to cancer. As to enlarged glands, he observed that these might be present in association with inflammatory lesions.

Dr. Campbell Pope then read a paper on "Twenty-five Years' Death Certificates," which we propose to publish in full in our next issue.

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

DE SENECTUTE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—One of the great changes made in medical staffs of the London hospitals during the last years has been the retirement of the physicians and surgeons on reaching the age of sixty. Whether advantages have attended this change is doubtful. The chief reason, I presume, that it has been made, was probably because it was the general opinion that at the age of sixty the energy and

powers required for the proper teaching of students and carrying on the work of the hospitals could not be retained after that age. When we see that some of those who have been obliged to retire on account of age are now arranging to carry on a scheme for educating by lectures and clinical instruction those members of the profession who desire to learn from those best qualified to teach, it would seem that the students at our hospitals, instead of gaining, must have lost much. To teach well is an art that requires long practice, and when we see such a man as the late Sir D. MacLagan continuing till long past the age of seventy to discharge the important duties of a professor in the great University of Edinburgh, I am disposed to question the wisdom of enforcing the retirement of the leaders at our schools at the age of sixty. Whether one of the causes for this was the influence of the younger members of the staff who were kept waiting sometimes for many years before they were allowed any share in the emoluments coming in from the students I will not discuss. I would rather consider the question in its relation to the students and the public, the latter of course being the patients in the hospital wards, and those interested in them. It is certainly not considered necessary in other professions, when mental energy and experience are of more importance than physical strength and activity, as in the Law and the Church, to make those who have followed them retire at the age of sixty. The dignitaries of the Church and the occupants of seats on the Bench are generally considered young if they have not reached that age; and when we see that the control of the great military work now being carried on in South Africa is entrusted to a general far beyond sixty, I am inclined to the opinion that what has been done in the profession will not bear favourable criticism. Who will suffer or are suffering most by this, remains to be proved, and though at first the sufferers may be the sexagenarians, if I may use such a term, it is probable that those who will suffer later and more are the public and the rising generation of students. Whether these can see their way to bring about some reform I think deserves their careful attention, and I venture to suggest the subject as one that for their own sakes they ought to take in hand soon.

I am, Sir, yours truly,

VALID.

Obituary.

MR. ARCHIBALD ROBINSON, OF DUBLIN.

THE sudden death of this much-esteemed gentleman, at an early age, was announced on last Friday. As he was not a member of our profession, but a solicitor, we should not feel called upon to notice the occurrence but for the intimate relation of the deceased gentleman to medical interests in Ireland. Mr. Robinson was for many years the advising solicitor to the Royal College of Surgeons and to the Irish Medical Association, and, in connection with the College, had carriage of the various changes of charters and bye-laws, the reconstruction of the Carmichael prize scheme, the legal adjustment of the amalgamation of the Carmichael and Ledwich Schools with that of the College, and all other matters requiring legal experience and discrimination. For the Irish Medical Association, Mr. Robinson advised upon and carried through the numerous legal contests promoted by the Association in defence of the interests of the profession in Ireland.

The loss of such a mentor to these institutions is incalculable, because he carries with him a special knowledge of the laws with which they are most concerned, and a thorough experience of precedents and practice. The loss is the greater in this case, because Mr. Robinson enjoyed in its plenitude the confidence of the executive of both bodies. Although it was necessary, from time to time, to reinforce his opinion with the advice of senior counsel, these executives accepted without hesitation his views, which they knew by experience were well-considered and cautiously expressed, and, in fact, seldom thought it necessary to confirm those views. His financial

relations with these bodies were always such that, in completing a transaction they felt themselves under an obligation to him, and not he to them.

New Appliances.

AN IMPROVED SUSPENSORY BANDAGE.

UNTIL recently the ubiquitous inventor seems to have devoted little or no attention to the amelioration of the suspensory bandage, a useful and often very necessary appliance, but the benefits whereof have, in the past, been discounted by the difficulty of maintaining it in position and the chafing to which it gave rise when displaced. We have, therefore, inspected every fresh design with interest, and among those which deserve favourable notice must be mentioned the pattern manufactured by the "Domen" Belts Company (456, Strand). The name "Stow-Away" bandage chosen for the article is certainly open to criticism, and makes it difficult for a surgeon to order such an appliance. So far as the bandage itself is concerned we have no hesitation in saying that it constitutes a distinct advance on anything of the kind we have yet seen and its construction is quite novel. It "sits" well and secures perfect comfort and protection of the external genitals. It is made in various sizes and qualities.

FOX'S SPAT-PUTTEE.

THE "Puttee" is a substitute for and an improvement upon, the usual woollen stocking recently affected by our South African troops, sportsmen, cyclists and others. It is made of pure soft wool and is applied to the leg like a bandage. The peculiar nature of the material of which the puttee is made and the special shape given to the manufactured article, enables it to be put on quickly and easily, and it adapts itself to the shape of the leg readily enough without any necessity for the customary back-twists. The Puttee supports the leg in a way that the stocking never can, and gives a smartness to the sporting attire all its own. Its use averts the feeling of fatigue and aching in the lower limbs which usually follows long continued spells of walking or standing, and it is specially valuable when there is a tendency to varicosity. From a medical point of view the Puttee is vastly more comfortable than an elastic bandage, and is more efficient as a support than the elastic stocking. A specially fine quality is made for ladies' use. They are manufactured by Messrs. Fox Brothers and Co., Ltd., Wellington, Somerset.

Literary Notes and Gossip.

THE report of the Army Medical Department for the year 1898 was issued on Saturday last as a Blue-Book. The letter from Surgeon-General J. Jameson, the Director-General of the Army Medical Service, is dated December 21, 1899.

MR. THOMAS CARWARDINE, assistant surgeon to the Bristol Royal Infirmary, has in the press a "Manual of Operative and Practical Surgery," which will be illustrated by over 500 original drawings by the author. The work will be published by Messrs. John Wright and Co., of Bristol.

PROFESSOR MONTENEGRO'S important work on the Bubonic Plague has been translated from the Spanish by Dr. Wm. Monro, and the author has written an additional chapter for the English edition, giving later researches and methods of prevention than were possible when the Spanish edition was published last year. The book is published by Messrs. Baillière, Tindall, and Cox.

MESSRS. MACMILLAN are issuing a series of "Manuals of Medicine and Surgery," of which the first was by Mr. Stoham, F.R.C.S., on "Surgery." We have now received Volume I. in the same series of "A Manual of

Medicine," edited by Dr. Allchin, senior physician to Westminster Hospital. The work will, we understand, be completed in five volumes of handy size, which we hope to bring under review later on.

SIR HENRY BURDETT'S little guide to the nursing profession for 1900 contains a large amount of information likely to be of value to women who propose to go through a course of training with the object of taking up nursing as a profession. It gives particulars of nurse training schools in the United Kingdom and abroad, together with an outline of the principal laws affecting nurses.

THE eighth edition of Dr. Macnaughton-Jones' work on "Diseases of Women" has just made its appearance, and is scarcely recognisable in comparison with previous editions. It has been entirely reset to a larger page, most of the illustrations are new; 28 new plates have been added of the most recent operations in this country, on the Continent, and in America, and the text has been written up to date; all of which will doubtless ensure for it a continuance of that success, which is so rarely accorded to medical works.

STUDENTS of botany will welcome the third edition of Mr. Ainsworth Davis's well known and greatly appreciated treatise on "The Flowering Plant," which has just been published. It is garnished by numerous illustrations, many of them new, and a special chapter on Ferns and Mosses has been added in deference to the general desire to introduce some account of cryptogams into school courses of botany. It seems paradoxical, but we have the author's assurance that "no book on 'The Flowering Plant' can be considered satisfactory or complete without some reference to the 'flowerless plant.'" There is an appendix dealing with practical work and a selection of examination questions.

THE second edition of Professor A. W. Mayo Robson's work on "Diseases of the Gall-bladder and Bile-ducts," the first of which has been out of print for two years past, has just made its appearance, and would have been still longer delayed, he tells us in the preface, but for the assistance of Dr. Macrae. The first issue was rapidly absorbed, it being considered the most authoritative pronouncement on the subject of which it treats. New chapters with records of further operative experience in 135 cases have been added and the new edition will doubtless further enhance the reputation of its distinguished author.

WE have received a large and artistically executed volume on the "Boyle System of Ventilation," containing a most interesting account of the system of natural ventilation for which Messrs. Boyle are famed. It contains an enormous number of useful plates illustrating the advantages of the well-known system as applied to hospitals, dwelling-houses, churches, factories, ships, &c. Like most successful devices, this system has its chief merit in extreme simplicity, which renders it incapable of failure, and requires neither attention nor expense for maintenance when once fixed. We commend the perusal of this work especially to hospital authorities and others interested in the practical ventilation of public buildings.

MR. CAMPBELL STARK'S "Aids to Practical Pharmacy" ("Aids" Series, Baillière, Tindall, and Cox), is intended to replace the "Practical Pharmacy for Medical Students," by the same author, of which, indeed, it may be regarded as a new and revised edition, brought into line with the "British Pharmacopoeia of 1898." The work, though of small compass, contains all the information required to pass the examination in practical pharmacy of the Conjoint Board, and would probably amply suffice to satisfy the requirements of any medical examining board in this department.

THE third and concluding volume, also belonging to the "Aids" series, on "Materia Medica," by Dr. W.

Murrell, completes what we are fain to regard as a very succinct account of the points of which medical students are required to possess a knowledge in respect of remedial agents. This closely printed, but small volume, in addition to an account of synthetical products and drugs of animal origin, comprises a brief review of the present state of our knowledge of glandular and serum therapeutics. This has been admirably and thought fully done, and the chapter will be found of exceeding usefulness to all practitioners of medicine; indeed, we know of no other work, accessible to us, in which this important subject is treated as adequately. The author's lucid style and careful literary handling give his resume a special and individual interest.

NEW BOOKS AND NEW EDITIONS.

THE following have been received for Review since the publication of our last monthly list:—

BAILLIÈRE, TINDALL AND COX (London and Paris).

Diseases of the Gall-Bladder, and Bile-Ducts, including Gall-Stones. Second edition. By A. W. Mayo Robson, F.R.C.S., assisted by Farquhar Macrae, M.B.C.M. Pp. 314. Price 10s. 6d.

Practical Manual of Diseases of Women and Uterine Therapeutics. By H. Macnaughton-Jones, M.D., M.Ch. Eighth edition, revised and enlarged, with 28 new plates, and 640 illustrations. Pp. 947. Price 18s.

The Bubonic Plague. Its Course, Symptoms and Means of Prevention and Treatment. By Dr. Jose Verdes Montenegro, Professor in the Municipal Laboratory, Madrid. Authorised translation by Wm. Monro, M.D. Pp. 84. Price 3s. 6d.

Diphtheria: Being the Harben Lectures delivered before the Royal Institute of Public Health, December, 1899. By Wm. R. Smith, M.D., D.Sc., F.R.S.Ed. Pp. 120, with numerous charts and tables. Price 6s.

Treatise on Orthopedic Surgery. By Edward H. Bradford, M.D., and Robert W. Lovett, M.D. Second edition with 621 engravings. Pp. 655. Price 18s.

Mock Nurses of the Latest Fashion, A.D. 1900. By Frederick Gant, F.R.C.S. Pp. 196. Price 3s.

CASSELL AND COMPANY, LIMITED (London).

Tuberculosis: Its Nature, Prevention and Treatment. By Alfred Hillier, B.A., M.D. Pp. 243, with three plates. Price 7s. 6d.

CHURCHILL, J. AND A. (London).

St. Thomas's Hospital Reports. New Series. Vol. XXVII. Edited by Dr. Hector Mackenzie and Mr. G. H. Makins. Pp. 463. Price 8s. 6d.

Ulcer of the Stomach and Duodenum and its Consequences. By Samuel Fenwick, M.D., F.R.C.P., and W. Soltau Fenwick, M.D., M.R.C.P. Pp. 392. Price 10s. 6d.

The Student's Handbook of Surgery of the Alimentary Canal. By A. Ernest Maynard, M.B., B.S.Lond. Pp. 510. Price 8s. 6d.

The Diagnosis and Treatment of Syphilis. By Tom Robinson, M.D. Pp. 138. Price 3s. 6d.

WILLIAM F. CLAY (Edinburgh).

Practical Text-book of Midwifery. By Robert Jardine, M.D.Ed. Pp. 245. Price 6s.

DOWNY AND CO., LIMITED (London).

Medicine and the Mind. Translated from the French of Dr. Maurice de Henry. By Stacy B. Collins, M.D. (U.S.A.). Pp. 373. Price 12s.

KEGAN PAUL, TRENCH, AND CO. (London).

Richter's Organic Chemistry, or Chemistry of the Carbon Compounds. Third American Edition from the Eighth German Edition. Translated by Edgar F. Smith. Pp. 671. Price 15s.

H. K. LEWIS (London).

Anæsthetics, their Uses and Administration. By Dudley W. Buxton, M.D., B.S. Third Edition. Pp. 329. Price 6s.

LONGMANS, GREEN, AND CO. (London).

The Morals of Suicide. By Rev. J. Gurnhill, B.A. Cantab. Pp. 227.

MACMILLAN AND CO. (London and New York).

The Nervous System of the Child; its Growth and Health in Education. By Francis Warner, M.D.Lond., F.R.C.P. Pp. 222. Price 4s. 6d.

A Manual of Medicine. Edited by W. H. Allchin, M.D.Lond., F.R.C.P., F.R.S.Ed. Vol. I. General Diseases. Pp. 442. Price 7s. 6d.

THE MEDICAL PUBLISHING COMPANY (London).

Heart Disease in Childhood and Youth. By Chas. W. Chapman, M.D. Durh., M.R.C.P.Lond., with an Introduction by Sir Samuel Wilks, Bart., M.D., F.R.S. Pp. 101.

DAVID NUTT (London).

The Frog, an Introduction to Anatomy, Histology, and Embryology. By the late A. Milnes Marshall, M.D., D.Sc., F.R.S. Seventh Edition. Edited by G. H. Fowler, B.A., Ph.D. Pp. 168. Price 4s.

OLIVER AND BOYD (Edinburgh).

Narrative of Cruises in the Mediterranean in H.M.S. *Euryalus* and *Chanticleer*. During the Greek War of Independence, 1822-26. By William Black, L.R.C.S.Ed., Surgeon H.M.S. *Chanticleer*. Pp. 356, with coloured and other plates. Price 11s.

POWSONBY AND WELDRICH (Dublin).

The Royal University of Ireland Examination Papers for 1899: a Supplement to the University Calendar for 1900. Pp. 761.

THE SCIENTIFIC PRESS, LIMITED (London).

Burdett's Official Nursing Directory for 1900. Edited by Sir Hy. Burdett, K.C.B. Pp. 684. Price 5s.

SMITH, ELDER, AND CO. (London).

Paralytic Deformities of the Lower Extremities: the Principles of their Surgical Treatment. By E. Noble Smith, F.R.C.S. Ed., L.R.C.P. Lond. Pp. 99. Price 3s.
Occasional Lectures on the Practice of Medicine. By W. B. Cheadle, M.D., F.R.C.P. Pp. 324. Price 7s. 6d.

Address of the Royal College of Physicians of Ireland to Her Majesty the Queen.

THE following loyal address was presented to the Queen last week:—

May it Please Your Majesty,—We, the President and Fellows of the Royal College of Physicians of Ireland, take the auspicious opportunity of your Majesty's visit to your Kingdom of Ireland and City of Dublin to give renewed expression to our devoted loyalty and attachment to your Majesty's Throne and person, and to assure your Majesty of the gratification we feel in the fact that you have been graciously pleased once more to honour our city and country with your august presence.

As physicians we recognise with grateful appreciation the favour which your Majesty has ever extended to our profession, and the kindly interest you have taken in its efforts for the advancement of medical science, as well as the preservation and improvement of the health of the nation. On our part we have on all occasions striven to further these great interests, which have been entrusted to us both by your Royal predecessors and by your gracious Majesty, in the successive Charters of our College.

We are deeply and gratefully sensible of the generous impulse which has prompted your Majesty at this time to visit Ireland and its capital—a gracious recognition of the heroic and conspicuous part which your Majesty's Irish troops have played in the war in South Africa. In this season of trouble you have—as you have ever done—made the trials and sorrows of your people your own, thus drawing their thoughts and hearts ever closer to your Royal person by ties of affectionate regard.

That the Almighty may be pleased to spare your Gracious Majesty to guide through years to come the destinies of the vast empire over which you have so long and so nobly ruled is the earnest prayer of us, your Majesty's loyal subjects and dutiful servants, the President and Fellows of the Royal College of Physicians of Ireland.

JOHN WILLIAM MOORE, M.D.,
Univ. Dublin, President.

JAMES CRAIG, M.D.,
Univ. Dublin, Fellow and Registrar.

The Thirteenth International Congress of Medicine, Paris, August, 1900.

WE are asked to remind our readers that the near approach of the International Medical Congress, which is to be held at Paris from August 2nd to August 9th, makes it necessary for everyone who intends to be present to provide himself with a ticket of membership as soon as possible. Application forms can be obtained from the secretaries of the National Committee for Great Britain and Ireland, Dr. A. E. Garrod, 9, Chandos Street, and Mr. D'Arcy Power, 10A, Chandos Street, Cavendish Square, London, W. Each form should be returned to the secretaries, duly filled up and signed, together with a visiting card attached and a cheque or postal order for £1. The application forms are then sent to Paris, and the applicant in due course receives a card of membership, which entitles the holder to attend the meetings of any section of the Congress, and to obtain from the secretary-general's office at Paris invitations, badges, and publications two days before the official opening of the Congress. After the conclusion of the Congress each member will receive an abstract of the proceedings in all the sections, and the detailed proceedings of the section in which he is more especially interested, as shown by his placing the section first upon his application form.

The ticket of membership is accompanied by a non-transferable form securing the bearer to a free return journey from Paris to the frontier by the same route and in the same class of carriage as he entered France. This order is available for the return journey from July 20th to August 20th, 1900. It has to be *visé'd* at the departure station, certified in Paris, and exchanged for a ticket on the return journey. The English railway companies are willing to give tickets to members of the Congress who present their membership cards at the time of booking. The South-Eastern and Chatham and Dover Railways charge first class 58s. and second class 37s. 6d., for return tickets available for 14 days by the 2.45 p.m. service via Folkestone and Boulogne and by the 9 p.m. service via Dover and Calais. Each ticket will entitle the holder to a free allowance of 56 lbs. of luggage, and will be available to return from Paris by the 3.45 p.m. or 9 p.m. services. The London, Brighton, and South Coast Railway have made arrangements for the issue of 14-day tickets from London or any station on the Brighton Railway to Paris and back at 39s. 3d. first or 30s. 3d. second class to members of the Congress. These tickets can be extended to 25 days if desired, and they allow the journey to be broken at Brighton, Lewes, Newhaven, Dieppe, and Rouen both going and returning.

St. Thomas' Hospital Medical School.

AT the recent examinations held at the end of the winter session, the following medals and prizes were awarded:—The Mead medal to Mr. R. B. Kinlock, the Cheselden medal to Mr. T. H. Edwards. A prize of £10 to each of the following:—Mr. F. C. Eve (medicine), Mr. W. H. O. Woods (surgery), Mr. T. S. Taylor (midwifery and diseases of women), Mr. J. E. H. Sawyer (pathology), Mr. J. L. Lock (pharmacology), Mr. R. B. Kinlock (forensic medicine and insanity), Mr. W. B. Fry (public health). The Peacock scholarship (£38 10s.), and a college prize of £20 were divided between Mr. H. S. Bennett and Mr. F. W. W. Smith (second year). The William Tile Scholarship (£27 10s.), to Mr. K. Takaki (first year).

Death Certification.

MR. McLAUGHLIN, practising in Battersea, was admonished on the occasion of an inquest last week for having certified the cause of death in respect of one of his patients to have been chronic bronchitis and senile decay, whereas, according to the divisional surgeon, death was due to serous apoplexy. The principal point was that Mr. McLaughlin had not seen the patient after March 27th, death having taken place on Good Friday. Assuming that the dates were correctly given in the certificate, we do not see that Mr. McLaughlin's conduct is open to criticism, for it is quite open to question which particular lesion determined death, the patient being 77 years of age.

University of Durham.

THE following candidates have passed the first examination for the degree of Bachelor in Medicine:—

OLD REGULATIONS.

1. Chemistry with Chemical Physics.—George Fowler, L.R.C.P. and S. E., D.P.H. Lond., Alexander Minter Watts, M.R.C.S., L.R.C.P.
2. Elementary Anatomy.—Ernest James Miller.

NEW REGULATIONS.

1. Elementary Anatomy and Biology, Chemistry, and Physics.—Honours—First Class: William Gibbons. Second Class: Fred. Stoker. Pass List: James Alexander Bennett, Walter Howard, Thomas Charles Hunter, Bernard Warner Lacey, Constance Charlotte Robertson, Janet Arthur Vaughan, Hermann Wolfe.
2. Chemistry and Physics.—Ambrose Harold Bateman, Cyril Priehard Burd, M.R.C.S., L.R.C.P., Charles Fisher, M.R.C.S., L.R.C.P., William Watkiss Jones, Sidney Nix, Percy Montgomery Rivaz, William Seymour, William Frank Wilson.
3. Elementary Anatomy and Biology.—Frederick Durnford Atkins, Llewelyn Alfred Henry Bulkeley, Fred Thomas Holloway Davies, Harold Edgar Featherstone, Albert James Gilbertson, John James Grant, Alfred Herbert Heslop, Lizzie Evelyn Kendal, Frederick William Kemp, Raghunath Vithal Khedkar, George Errington Lloyd, Colin Francis Frederick McDowall, Bertha Mary Mules, William John Phillips, B.Sc., Mary Raw, Charles Duncan Belton, Olga Schiele, Francis Rupert Snell, Frederick James Strachan, William Lister Tindle, Tys Visser.
4. Elementary Anatomy, Chemistry, and Physics.—Alfred Reid, Guy's Hospital.

Notices to Correspondents, Short Letters, &c.

✎ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a distinctive signature or initials, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

HEALTH HINTS.

We have boiled the hydrant water;
We have sterilised the milk;
We have strained the prowling microbe
Through the finest kind of silk;
We have bought and we have borrowed
Every patent health device,
And at last the doctor tells us
That we've got to boil the ice.

—*Southern Med. Jour.*

SPES.—A medical man ought always to tell the truth, but he is under no moral or legal obligation to tell all the truth. This is a matter well within his discretion. It has often been observed, too, that frankness does not always make success in medical practice, indeed, the patient is perhaps the only person who will not trust you when you say "you don't know." It is unnecessary to parade one's ignorance, however excusable it may be, and a judicious caution in formulating a definite opinion is all that the most fastidious can demand.

MR. JOHN MCKAY.—Your letter has been forwarded to the editor of the division in which you reside. Delay is necessarily entailed by disregarding this rule.

M. K.—It may not be actually illegal, but it is assuredly unbecoming for a registered medical practitioner to allow his name to be associated with a proprietary nostrum. Whether or not the General Medical Council would consider such an association "infamous conduct" must depend upon circumstances. We can recall more than one case in which the names of offenders of this sort have been removed from the Register.

ONE BY CHOICE.—A Paris journal gives the number of prostitutes registered at 5,183. Of these 1,440 are forced to the life by poverty, 1,255 are orphans, having no other way to obtain shelter; 280 are widows from the provinces unable to obtain an honest living; 404 are young girls brought from the country by soldiers and others; 289 are domestics discharged after being ruined by their employers; 1,425 have been deserted by faithless lovers; 89 admit adopting this life to support the family. This leaves one to be put down to pure depravity. —*New York Medical Record.*

INTENDING VISITORS TO THE PARIS EXHIBITION.

—The *Sanitary Record* having inaugurated a personally conducted seven day trip to Paris (under special sanction of the Paris Municipality) cordially invites readers of THE MEDICAL PRESS and CIRCULAR to participate. The rates are exceptionally low, and the programme attractive, appealing to the members of the medical profession interested in public health problems. For full particulars apply to "Director, Paris Excursion, *Sanitary Record*, 5, Fetter Lane, London, E.C."

Meetings of the Societies and Lectures.

WEDNESDAY, APRIL 25TH.

HUNTERIAN SOCIETY.—8.30 p.m. The President: Traps and Pitfalls in Special and General Practice. After the address there will be a Discussion in which Fellows and their visitors are invited to join.

THURSDAY, APRIL 26TH.

DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND (20 Hanover Square, W.).—4.30 p.m. Informal Exhibition of Cases. 5 p.m. Ordinary Meeting.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (20 Hanover Square, W.).—8.30 p.m. Dr. A. S. Myrtle (Harrogate): Personal Experiences of Gout. Paper:—Dr. L. Gordon (Forest Hill): The Climate and Hospitals of Rhodesia (illustrated by lantern slides).

FRIDAY, APRIL 27TH.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m. Clinical Evening. The following cases will be shown:—Dr. N. Dalton: A Case of Aortic Regurgitant Murmur heard in the Pulmonary Area.—Dr. Habershon: A Case of Tuberculous Gland in the Anterior Mediastinum (with radiograph).—Dr. P. Kidd: A Case of Lymphatic Leucocythæmia.—Dr. H. Campbell: A Case allied to Rockingham's Disease.—Mr. C. Symonds: A Patient after Complete Removal of the Clavicle.—Sir Hugh Beevor: A Case of Diffuse Lipomata of the Limbs.—Dr. N. Dalton: A Boy with (apparently) Tuberculous Mediastinal Glands Pressing on the Right Lung.—Mr. Lunn: A Case of Osseous Tumour of the Arm (with a skiagraph).—Mr. T. D. Savill: A Case of Macular Leprosy improving under Chanmoogra Oil. Patients will be in attendance at 8 p.m.

Appointments.

BRAND, G. H., L.R.C.P., L.M.Irel., L.S.A., Honorary Medical Officer to the Northampton and County Association for the Blind.

HAYES, A. HERBERT, L.R.C.P.Lond., M.R.C.S., Medical Officer to the Casualty Department, East London Hospital for Children and Dispensary for Women, Shadwell, E.

MARTIN, JOHN MIDDLETON, B.A., M.B., B.C., D.P.H.Cantab., L.S.A., Medical Officer of Health for the Stroud (Gloucestershire) Rural District vice Thomas Partridge.

PEARSON, SYDNEY VERE, B.A., B.C.Cantab., House Surgeon to the East London Hospital for Children, Shadwell.
PHILIP, W. M., M.B., C.M.Aberd., D.P.H., Medical Officer by the Aberdeen City Parish Council.
SHARP, HUGH CULLIFORD, B.A., M.B., B.C.Cantab., Medical Officer of Health for Truro.
SMITH, C. CHANMOCK, M.R.C.S., L.R.C.P.Lond., Junior House Surgeon to the York County Hospital.

Vacancies.

Bath Royal United Hospital.—Resident Medical Officer for three years. Salary £100 per annum, with board, lodging, and washing.
British Ophthalmic Hospital at Jerusalem.—Surgeon as Clinical Assistant for eight months from June. Honorarium of £100, in addition to travelling expenses and maintenance.—Apply to Mr. B. Carter, F.R.C.S., 31, Harley Street, London.
Cumberland and Westmorland Asylum, Garlands, Carlisle.—Junior Assistant Medical Officer, unmarried. Salary £100 a year, with board and residence.
Fisherton Asylum, Salisbury.—Assistant Medical Officer. Salary £150 per annum, with board, lodging, and washing. Apply to Dr. Finch, Salisbury.
Glamorgan County Asylum, Bridgend.—Junior Assistant Medical Officer. Salary £150, with board, apartments, washing, and attendance.
Halifax Union Workhouse, St. Luke's Hospital.—Assistant Medical Officer for this hospital and workhouse, unmarried. Salary £180 per annum, partial board. Apply to the Clerk to the Guardians, Union Office, Halifax.
Kidderminster Infirmary and Children's Hospital.—House Surgeon, unmarried. Salary commencing at £140, increasing annually by £10 to £170, with rooms in the Infirmary and attendance. Option of board at £40 per annum.
Liverpool Dispensaries, Moorfields, Liverpool.—Assistant Surgeon, unmarried. Salary £100 per annum, with board and apartments.
Parish Council of Uig, Island of Lewis.—Medical Officer and Public Vaccinator. Salary £200, exclusive of certain fees. Applications to the Chairman of the Parish Council.
Ripon Dispensary and Cottage Hospital, Ripon.—Resident House Surgeon and Dispenser, unmarried. Salary commencing at £70 per annum, with board and lodging.
Royal National Hospital for Consumption at Ventnor.—Clinical Assistant. Board, residence, and laundry provided. Apply to the Secretary, London Office, 34, Craven Street, Strand.
Staffordshire General Infirmary, Stafford.—House Surgeon for two years. Salary £120 per annum, with board, lodging, and washing.
Stamford Hill and Stoke Newington Dispensary, Stoke Newington, London, N.—Assistant Resident Medical Officer. Salary £100 per annum, with board and residence.
Western Dispensary, Rochester Row, Westminster.—Resident Medical Officer. Salary 100 guineas per annum, with residence, coals, gas, and attendance.
Wolverhampton and Staffordshire General Hospital.—House Physician for two years. Salary £100 a year, with board, lodging and washing.

Births.

FLEGG.—On April 17th, at Southdene, Woodford, Essex, the wife of F. A. Martin Flegg, M.R.C.S., L.R.C.P.Lond., L.S.A., of a son.
FLEMING.—On April 18th, at 10, Chester Street, Edinburgh, the wife of Robert A. Fleming, M.D., F.R.C.P.E., of a daughter.
KERR.—On April 17th, at London Road, Sheffield, the wife of W. S. Kerr, M.B., of a son.
MILLIGAN.—On April 18th, at Westbourne, Rusholme, Manchester, the wife of William Milligan, M.D., of a daughter.
OxLEY.—On April 18th, at Shanklin Villa, Buckhurst Hill, the wife of Fredk. J. Oxley, M.R.C.S., L.R.C.P., of a daughter.

Marriages.

BROOKS—REZIN.—On April 18th, at Old Aberdeen, John Harley Brooks, M.D., of Mile End Infirmary, London, to Eliza Alice, third daughter of George Rezin, Esq., of Primrose Hill, Old Aberdeen.
BRYANT—FRY.—On April 18th, at St. Luke's Church, West Norwood, John Henry Bryant, M.D., B.S., M.R.C.P.Lond., Assistant Physician to Guy's Hospital, eldest son of the late William Mead Bryant, of Ilminster, Somerset, to Stella Beatrice, sixth daughter of Richard Fry, of Baulthill, Norwood.
DIMSEY—WHITTING.—On April 17th, at Holy Trinity Church, Weymouth, Staff-Surgeon Edgar B. Dimsey, D.S.O., Royal Naval Sick Quarters, Portland, to Edith Elizabeth, eldest daughter of the late Rev. W. H. Whitting, Rector of Stover Priory, Dorset.
LYALL—NORRISH.—On April 19th, at the Church of the Holy Cross, Crediton, David William Knyvett Lyall, M.B.O.M. Ed., of Shepton Mallet, Somerset, to Mary Ayre, younger daughter of D. M. Norrish, Esq., of Crediton, Devon.
MOON—DAY.—On April 18th, at St. Marylebone Parish Church, London, Edward Gibson Moon, M.D., of Broadstairs, to Annette Day, of 6, Gloucester Street, Portman Square.
WILLET—DUNCAN.—On April 19th, at All Saints', Minstead, Hants, Herbert Burrows Willett, eldest son of Alfred Willett, F.R.C.S., 36, Wimpole Street, London, to Isobel, eldest daughter of the late J. Matthews Duncan, M.D., F.R.S., and Mrs. Matthews Duncan, of Minstead Lodge, Hants.

Deaths.

COCKCROFT.—On April 12th, at Manor Lodge, Chislehurst, Thomas Howarth Cockcroft, M.D., in his 75th year.
OAKLEY.—On April 13th, at Frogmal, Hampstead, Harry Callander, Oakley, L.R.C.S., L.R.C.P. Edin., aged 46 years.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX"

VOL. CXX.

WEDNESDAY, MAY 2, 1900.

No. 18.

Original Communications.

TWENTY-FOUR YEARS DEATH CERTIFICATES IN GENERAL PRACTICE. (a)

By H. CAMPBELL POPE, M.D.Lond.,
F.R.C.S.Eng.,

Ex-President of the West-London Medico-Chirurgical Society.

THE busy general practitioner has little time to take note of what he is doing, and he sees no such results growing round his work as is the case with those who practice in a less extended sphere of human pathology, and who draw large deductions, and may I say larger emoluments, from a minute study of isolated portions of the fields of medicine and surgery.

But it occurred to me that though our hospitals continually publish the results of their work, the far greater work and gathered experience of thousands of practitioners dies with the men themselves, and little is known of what cases pass through their hands or what deductions they may have drawn from their experience. It then struck me that the counterfoils of my death certificate books might be of some service in showing, possibly, what diseases were prevalent in that portion of the West of London in which I practice, and also might throw some light upon hereditary transmission of disease. But I approached the subject with a perfectly open mind and determined to tabulate the certificates and see if any useful results would flow from their inspection. I found that a great variety of diseases entered into the composition of such a tabular form, and that the incidence of disease in the locality was not such as I judged it to be, previous to starting this investigation. The total number of deaths during the period was practically about 600. I have tabulated 595 of these, but a considerable number of inquests, in fact all but one case, a death from chloroform inhalation, have been omitted.

The first section I have tabulated is malignant diseases, which shows 51 deaths out of 600, equal to one in 12, which quite surprised me, as I had no idea that there was anything like so great a proportion. Of these 14 were of the liver, 12 of the uterus, three of the intestines, five of the breast, two of the rectum, one each of stomach, pylorus and rectum, pancreas, kidney, inguinal glands, penis, tongue, jaw, cheek, tonsil, and foot, two of the brain; and three sarcomas, two of the kidney and one of the mediastinal glands.

As regards the liver cases there is no doubt that alcohol had a good deal to do with them, several of them were large drinkers especially of whiskey, and in some of the other cases gall-stones were present, in one of the cases kindly recommended to me by my

friend, Mr. Kestley, there was an immense gall-stone impacted in the common bile duct, which I have here. In all these cases, I should look upon the alcohol and the gall-stones as constituting the primary irritants which seem so often to precede cancerous developments.

As regards the uterine cases only one was operated on, and did well as regards the cancer which was of the fundus, but the ureter was wounded in the operation and pyelitis resulted, ultimately attacking both kidneys. Of the breast cases, secondary developments in the liver were observed twice, in the brain once, in the œsophagus and stomach twice, and in the lungs once. The case of cancer of the kidney occurred in the person of a patient affected with hæmophilia and was fatal from hæmorrhage. The case in the inguinal glands was primary, and death occurred from ulceration into the large vessels. The prominent symptom in one of the brain cases (glio-sarcoma) was pain of the most intense character. The two cases of sarcoma of the kidney were both interesting, one, a little girl, had secondary sarcoma of the liver and was in a cataleptic state for a long time before death. In whatever position the limbs were placed, even the fingers, there they would remain. The other case was a barrister who once passed an oxalate of lime calculus, he then suffered with renal abscess which burst periodically, many times through his lungs and the contents were expectorated; ultimately sarcoma of the kidney and the glands right up to the cervical region supervened. The case of mediastinal sarcoma was seen by our President, the patient died of suffocation, a large quantity of soft material was expectorated and the lungs were flooded by it, causing the patient's death. These are of course all deaths from cancer, of other cancer cases which have come under my notice I have found those of the breast most amenable to operative treatment.

Diseases of the Kidneys.—"Chronic Bright" is answerable for seven out of the 14 deaths, these cases mostly died of heart or lung complication. Over and above these ordinary cases was one of "chronic Bright," in which innumerable calculi were passed from the bladder by a woman. Twenty or even 30 at a time were quite common, and this went on for years, the calculi were of the size of lentils or small peas, and mostly round. Chronic Bright, with attacks of much albumen is not so formidable as the constant passage of small amounts. Three other cases ended in uræmia. One, a very remarkable case of a most distinguished musician, was complicated by diabetes and eczema of the legs. The discharge of water from the eczematous legs was enormous, and doubtless to some extent purified the blood; this gentleman was a great worker, and to the last persisted in his duties, working 10 or 12 hours a day at composing or musical editing, although he could only move with difficulty from his chair. Another good and instructive case was that of an actor who, after a long railway journey, and sea trip to the Isle of Man, arrived heated at the theatre,

(a) Paper read before the Medical Society of London, April 23rd 1900.

which was very draughty. He played his part, but found he could not pass water on his return home to his lodgings. In the morning the same occurred, and he consulted a doctor, who passed a catheter with no result. He then returned to London, and was under my care for several days, and was seen in consultation by Dr. Stephen Mackenzie, but our efforts to induce the flow of urine were unavailing. A case of stone in the bladder was of some interest, in a little girl of three, this I removed, and she went on well until she was about 16, when she showed signs of stone in the kidney. She was operated on in University Hospital by Mr. Marcus Beck, and a fistulous opening remained in the back. She had several attacks of uræmia, and ultimately died in one nine years after, at the age of 25.

Diseases of the Lungs.—Of these, which are 170 in number, and form by far the largest section of my table, the cases of bronchitis are most numerous, the acute cases being 30 and the chronic cases 23. These are independent of the cases of whooping-cough, which I have placed in a separate sub-section. The great majority of the acute cases were in children, and some few in old people without pre-existing chronic bronchitis. Of unusual causes of bronchitis, one was due to the fumes of vinegar; a gentleman received an appointment in a vinegar factory, and his first experience of the fumes was fatal to him. Two of the cases of chronic bronchitis presented this peculiarity that the lungs would become suddenly oedematous, and put the patient in danger for several days. In one of these two cases the man's hair turned grey in each attack, and resumed its pigmentation in three or four weeks after the attack was over. *Phthisis* accounted for 42 deaths; this somewhat surprised me, as we have been accustomed to think of Shepherd's Bush as a place where phthisis is comparatively unknown. It has been more prevalent during the last ten years, since influenza made its appearance, but cases due to influenza I have relegated to an Influenza Section. It would take far too long to go into points connected with these cases of phthisis. I would only refer to three, in which death occurred from pneumothorax. Two of these were in young girls. The bursting occurred in a paroxysm of cough, and both had subcutaneous emphysema. The third case was a man who was going to be operated on for fistula. While inhaling chloroform before the operation he suddenly died, and it was found post-mortem that a sub-pleural cavity in the apex of one of his lungs had burst. Of the other respiratory cases, 12 were broncho-pneumonia, four catarrhal croup, three laryngismus stridulus, two congenital asthma; one of plastic bronchitis in a young domestic servant, who slept over a stable; one of tonsillitis. It may be of interest to note the complications which caused death in 24 cases of whooping-cough. In one, vomiting; in six, bronchitis; in five, convulsions; in seven, pneumonia; in one, pleurisy; in one, harelip and cleft palate, which caused an extraordinary embarrassment of breathing; in one, meningitis; and in one, broncho-pneumonia. Pneumonia was the commonest cause of death.

Diseases of the heart and circulation were 46 in number. Four of these were congenital. These died at the following ages:—seven years, 38 hours, 21 years, and 22 years. All were cases of morbus ceruleus and had right side heart disease. One case of aortic aneurysm. One case was complicated with hæmophilia, and was husband to the lady who died of kidney cancer and hæmophilia; their family, both males and females, have hæmophilia, and one daughter died from hæmorrhage during typhoid fever, which will be mentioned later. I have had several exciting times with them after dental extractions and quinsies to which they are subject. One

case was complicated by obesity considerably over 20 stones. One case had moist gangrene of the whole leg. One case had a large gangrenous ulcer of the leg, which was excised by my friend, Mr. Keetley, and did well for a time. One case of phlebitis of the arms and legs in a stout lady, died suddenly 10 minutes after my visiting her, when she was sitting up enjoying her lunch.

One case of heart disease had extreme pain, Dr. Mitchell Bruce saw the case with me several times, but we could not exactly determine its nature, and no post-mortem examination was allowed. The man would shout with agony, but there was not extreme dyspnoea. One case of adherent pericardium simulated aneurysm, and the patient died momentarily from rupture, a huge quantity of blood pouring from the mouth. On the whole organic heart disease would seem to be a favourable sort of disease to have, the average age of the 46 deaths being 57½ years, even including the young congenital cases. I think this is perhaps, too favourable a view, as inquest cases are excluded from this table. Many such cases are heart cases, and very often in those who are not aware of any heart trouble being the matter with them. Those who are aware of their infirmity will sometimes take great pains not to over exert or flurry themselves, and consequently live on to old age. Two of the cases of mitral disease were brother and sister, aged about 70. The late Sir Andrew Clark said to me, I do not give a despondent opinion in cases of mitral murmur.

Scarlatina accounts for nine deaths. Three of these were scarlatina anginosa with a gangrenous condition of the cervical glands. These cases begin with an acrid discharge from the nose, and I have a strong suspicion that they are cases of post-nasal diphtheria with scarlet fever, and I think it would be well in such cases to use the diphtheria antitoxin. One other case was evidently associated with diphtheria. In one of the cases the finger could after death be passed right through the neck, the destruction having been complete on both sides. In this same house a boy of another family several years afterwards died of diphtheria. The complications in the remaining five cases, were one scarlatina maligna, one general eczema, two of nephritis, and one of parturition.

Typhoid.—Four deaths occurred from typhoid, one from convulsions, one with whooping cough as well, one with tuberculous meningitis, and one the hæmophilia case mentioned above. This young lady had nursed her mother for several months with cancer of the kidney, and was much run down in health when she was stricken with typhoid and died of hæmorrhage.

Diphtheria.—It was seven years after I started practice before I saw a case of diphtheria, then, in an evil hour, the London School Board secured a cheap site, where a marshy pond existed, and had existed for years. This they somehow dried and built a board school over it which fell down before the roof was finished. It was situated so low, below the level of the sewer that it was impossible to drain the school, and a great collection of impurities took place in the unhealthy foundations. Diphtheria soon started, and there it has remained ever since. Nearly all our cases of diphtheria came from the district supplied by this school. The first case was a very severe one, and I urged the father to leave the house, as I felt sure that drainage had something to do with the matter, being in such close proximity to this unhealthy place. He did not agree with me, and the following year he lost two more of his children, one with general paralysis after the attack. Thus, of the five fatal cases, three were in one family. Numerous deaths of children from that school have occurred, many in the Fever Hospital.

Measles.—Of the 18 measles cases, one died of

abscess and pyæmia, one of convulsions, nine of pneumonia, one of pneumonia and apoplexy, this was an adult woman of 34. One of hæmorrhagic measles, a child on whom I had previously performed inguinal colotomy for congenital deficiency of the rectum. This case is reported in the "Proceedings of the West London Medico-Chirurgical Society," Vol. I. One case, also an adult lady of 29, died of acute mania with measles, she was addicted to alcohol. The other cases had bronchitis (two of them), and one also had diarrhoea, only one case was uncomplicated. The point of note is that the two adult cases died of cerebral complications.

Diabetes.—Eight. Two died of coma, one of congestion of the liver and jaundice, one chronic case succumbed to influenza and pneumonia, and one was exhausted by a large carbuncle on the abdomen of the size of a cheese plate.

Rheumatism.—Of these complaints there were 11 deaths; two had chronic bronchitis, and one pericarditis in addition; one had hyperpyrexia. This was a case to remark. A gentleman went for a bicycle ride in an East wind; he sweated profusely. To his surprise, when he got home the sweating continued, and he felt ill and sent for me. I found him sweating profusely, temperature varying from 103 to 105. This went on for some days, when Dr. Wilks saw him with me; but the sweating and fever persisted till death. One case had phthisis. Three had heart complications, and one tonsillitis, hæmoptysis and hæmatemesis; one was a case of rheumatoid arthritis.

Senile Decay.—Eight uncomplicated cases, the oldest was 95. One case was Raynaud's disease; nearly all the toes fell off, and the tip of the nose,

Influenza.—I was pleasantly affected in studying these certificates to find how few deaths there were considering the enormous number of patients treated. Influenza accounted for 18 deaths, and I think 5,000 would be a modest estimate of the cases medically treated in the practice. Of these cases, one died of cardiac failure, two of pneumonia (there was also the gentleman named under diabetes), one of phthisis, one of pneumonia and phthisis, one of diarrhoea, vomiting and coma vigil, one of abscess and erysipelas, one of cystitis and septicæmia, and one of pleuro-pneumonia. There was no death from influenza *per se*, and I have little doubt that few of these patients would have died had they taken to bed on the first symptoms appearing. That is the essence of influenza treatment, and I find salicylate of soda and citrate of potash in the early stage, and quinine and nux vomica in the convalescent stage, sufficient for nearly all cases. Phenacetin is most useful for the pain. I have digressed somewhat here, for so many fatal results have occurred through indiscretions in regard to chills during the early stages of the disease, that I think the point cannot be too strongly insisted on. In 1889 I called attention to this point in the *British Medical Journal*.

Of general tuberculosis there were two cases, one died of diarrhoea and exhaustion, and both were under one year. The two tetanus cases were both tetanus neonatorum, the old plan of carbonising the rag used for unwrapping the navel cord doubtless sterilised the linen and had something to recommend it. Experience showed that cords so dressed did not stink.

Hæmophilia.—Two cases are noted under this heading, although three others which have been already alluded to died from intercurrent of other diseases. One of the two was an infant who died of umbilical hæmorrhage. The other was a case of great interest, and was under observation for many years. His chief trouble was hæmorrhage into the knee-joints which frequently occurred. His fatal attack was in the brain.

The Liver cases were 14 in number. One was a malarial case, one a case of atrophy, three of gall-stones, and the others cirrhosis, probably all alcoholic cases.

Gout (9).—These were all chronic cases. Three died of bronchitis, one was very interesting in this way. At the age of 76 she had whooping-cough, which resulted in bradycardia, with a pulse averaging 40; this rate persisted until she died in January last at the age of 87. Another case had rheumatic fever, with mitral disease and dropsy, which is interesting as showing that the two poisons may co-exist, I have reason to believe that this is not infrequently the case. A third case had gouty kidney, and at one period of his illness was afflicted with ulceration of the inguinal glands, this was very extensive and deep; Mr. Thomas Bryant saw the case with me, and we agreed that probably the cause of it was the gouty poison. He escaped ulceration into the deep vessels, and lived for several years after, ultimately dying of hemiplegia. Of the remaining two cases one was afflicted with senile decay, the other with fatty heart.

Anæmia was answerable for three deaths. Two were of the pernicious variety.

Purpura (1).—The patient, a girl of 16, died from exhaustion consequent on hæmorrhage from the gums and hæmatemesis.

Debility and Malnutrition.—Under this heading 62 deaths are noted. Of congenital debility there were 26 single infants, four pairs of twins, and one set of triplets; premature birth accounted for 14; rickets and convulsions for five; syphilis and convulsions for three, marasmus and convulsions for two, and rickets and purpura for one. There is here a considerable waste of infant life, and I cannot doubt that many cases of congenital debility and premature birth result from the medicines which are used to procure abortion and the means employed to prevent conception. These practices are widespread among all classes, and it is much to be desired that the authorities would compel the advertising press to close its columns to notices of nostrums and implements devoted to these ends. The Medical Defence Union has done much in this direction, but without the support of those in authority it cannot do much more. The matter is one in every sense of vital importance; for the future of the British Empire is greatly concerned in the prompt and ample supply of healthy British children.

Diseases of the Brain and Nervous System.—These diseases caused 69 deaths; 17 were hemiplegia, 13 tuberculous meningitis, which appears to me a somewhat large proportion, seven of simple meningitis, four of convulsions (cause unknown), four of cerebral softening, two of chronic spinal meningitis, these are interesting cases and have been fully described by Dr. Barlow; one of chronic imbecility, two of chronic alcoholism. As regards alcoholism, many cases under liver and kidney were alcoholic. These two were uncomplicated alcoholism, two of spina bifida, two of meningo-cele, six of dentition and convulsions, one of sclerosis of the brain, one of cerebral tumour, and one of paralysis agitans. The case of cerebral tumour was a little girl—she was quite blind and suffered much pain; the case was seen by Dr. James Taylor with me. The case of sclerosis of the brain was a singularly pathetic one. The causation was alcoholic. I had occasion to speak to the lady on the cause of her disease, and she seemed to pay attention to my words, a very unusual fact in an alcoholic female; at any rate she dropped her stimulants, and almost immediately afterwards her husband failed in business and this seemed to complete the reformation in her habits. She buckled to and kept the home together in a most exemplary manner, and was the means of restoring the position of her family; she died shortly after her husband

gained another situation and fortune was again smiling upon them. In a large experience of such cases she was the only female I ever saw reform from moral motives.

Extra-uterine Gestation is, perhaps, badly described. The case was one of impregnation in an undeveloped horn of a uterus bicornis unicollis, and is fully noted in Vol. 28 of the Obstetrical Society's "Transactions," page 70.

Ovarian and uterine cases, exclusive of cancer, only number two deaths, one of ovarian dropsy and one of peritonitis occurring in a case of chronic endometritis.

Parturition.—The deaths connected with childbed are nominally eight, but half of them were connected with other serious diseases. In one case advanced phthisis, in another tuberculous peritonitis and supuration brought on premature labour; this was operated on by Mr. Keetley. In a third case I was called to a woman who had been attended by a midwife, who ran away from the case. I found the woman moribund from heart disease and cardiac asthma, and bleeding profusely from placenta prævia. I delivered by turning as rapidly as possible, but she only survived one hour. In another, advanced heart disease caused fatal post-partum hæmorrhage. The remaining four cases were more legitimate puerperal deaths. One from septicæmia and clots in the heart, one from uræmic convulsions, one from violent ante-partum hæmorrhage, and one from peritonitis. Total number of parturition cases, 1,700.

Hernia.—One case only ended fatally. An old inguinal hernia became obstructed in a man of 83, with fatal result.

Erysipelas and Septic Diseases.—Three cases of otitis died: one with erysipelas, one with meningitis, and one with septic broncho-pneumonia. Three ordinary cases of erysipelas. One case of septicæmia from umbilical putridity, one of senile decay complicated by abscesses, and one—a case of some interest—of severe scalp wound, with prolonged suppuration ending in albuminoid disease of the kidneys and liver. This gentleman survived the injury a year and a day, thus exactly escaping an inquest by the legal limit of time. This is a point not always understood by members of the profession.

Diseases of the Digestive System accounted for the decease of 42 persons. Of these 29 were diarrhœa and gastro-intestinal catarrh, four of obstruction of the bowels, which possibly in these later days might have been cases of appendicitis and operated on; four of gastritis and jaundice, one of glossitis and asphyxia, one of dysentery, and three of peritonitis. With regard to the 29 cases of diarrhœa, most of these were infants. Here I cannot refrain from noting the increasing prevalence of the custom of avoidance of suckling. Two principal reasons may be adduced for this—one the necessity of earning a livelihood among certain classes, the infants being put out to nurse, the other a dislike of trouble and an unfounded fear of losing their figure among better-to-do people. Some few appear to have no milk supply. Whatever the cause of the loss of maternal nourishment may be, the result to infant life is disastrous, notwithstanding the glowing advertisements of various artificial foods. If only one month of natural feeding can be gained it is a great advantage.

Lymphadenoma.—One case occurred, death at 13 years of age.

Bladder diseases were answerable for five deaths. One from tuberculous ulcer and general tuberculosis. This was in the early days of the cystoscope, and the ulcer was clearly shown by Mr. Hurry Fenwick. One case of cystitis and pyelitis, two of enlarged prostate and cystitis, one of calculus and supra-pubic cystotomy; this case was also operated on by Mr. Keetley.

Inflammation of the Lower Jaw killed the last patient on my list at the age of five week.

Mr. President and Gentlemen,—I fear I have wearied you by this long recital, but nevertheless, I think if this or some other plan could be devised by which general practitioners could save for collation, the results of their experiences a great gain would be derived. Especially might this be done with advantage in localities, say by societies such as now exist in most districts of London. When about ten years ago I had the honour of occupying the chair of the West London Medico-Chirurgical Society, I devised a case-taking form which was adopted by the Society its object being to collect information as to the effects of environment and heredity in determining the structure and present condition of any individual on the lines laid down by Dr. Harry Campbell in his remarkable work on "The Causation of Disease." I still think much might be done in this direction by general practitioners.

You may ask, and what is the conclusion of the whole matter as regards the facts just brought forward? To this I would reply, that the district I practice in would seem to be more afflicted with respiratory diseases than anything else; that infectious diseases are not very prevalent, mainly due, as I believe, to the excellent arrangements of our local medical officer of health, Dr. Collier, that cancer appears much more frequently than I had thought possible; and that influenza is not a remarkably dangerous disease if taken in time, and that there is a lamentable preventible wastage of young human life.

In conclusion, I have to express my indebtedness to my partner, Dr. Hill-Wilson, to my assistant Dr. Viliesid, and to other gentlemen who have worked with me for a good many of the material facts set down.

SOME CASES OF HYSTERECTOMY FOR CARCINOMA AND FOR MYOMA. (a)

By F. BOWREMAN JESSETT, F.R.C.S.,
Surgeon to the Cancer Hospital.

CASE I.—*Vaginal Hysterectomy for Carcinoma Uteri.*

MRS. D., æt. 56, was sent to me by Dr. Aust Laurence, of Clifton, and Dr. Broughton, of Usk, on February 3rd, 1900. She was the mother of five children, the youngest being 13 years of age. Had had good, though tedious labours. Menopause occurred about eighteen months since. On October, 1899, patient noticed slight hæmorrhage; she had suffered from discharge from that time until the time she consulted me, the discharge was offensive and often blood-stained. She suffers no pain nor any bladder or rectal irritation. She has lost flesh slightly, but is now a tall, fine-looking woman.

On abdominal examination nothing is found, no tenderness on either iliac region, and no enlargement of any of the organs.

Per Vaginam.—A quantity of foul smelling discharge is seen escaping from the vagina, on digital examination a large cauliflower growth is felt filling the vagina, the finger can be passed readily around it. The vaginal walls are free as well as both fornices. The uterus is perfectly mobile, and there does not appear to be any thickening in either broad ligament. I advised immediate operation, and on February 6th, with the assistance of Mr. Ryall and Mr. Murray,

(a) Specimens shown and notes of the cases read before the British Gynaecological Society, April 19th, 1900.

Dr. English giving the anæsthetic, I performed vaginal hysterectomy.

The patient made an uninterrupted recovery, and left the home a month after the operation.

CASE III.—*Vaginal Hysterectomy for Carcinoma Uteri.*

Mrs. K., æt. 38, sent to me by Dr. Fielden, Burgess Hill, suffering from vaginal discharge on February 24th, 1900. Has been married for two years; no family. Has always been regular until lately, when she has at times had some slight metorrhagia; has suffered from leucorrhœa for some time, and of late the discharge has become yellowish, thick, and occasionally blood-stained. Has slight pain in left iliac region, and no irritation of the bladder.

Dr. Fielden advised her to consult me, as he was of opinion that she was suffering from carcinoma of the uterus.

Abdominal examination revealed nothing. The patient was a well-nourished, healthy-looking, young woman. *Per Vaginam.*—There was a very distinct fungoid growth from the os on the anterior border. The mucous membrane over cervix and fornices were quite healthy. The uterus was freely movable. Examination caused slight bleeding. I agreed completely with Dr. Fielden, and looking upon the case as one of early carcinoma, and recommended vaginal hysterectomy. With the assistance of Dr. Fielden and Dr. Scott, Dr. English giving the anæsthetic, I operated. After dividing the mucous membrane round the cervix, and while using only slight traction, the vulsellum forceps tore through the uterine tissues. It was then discovered that the uterus itself was extensively diseased, being so rotten that it was with difficulty the forceps could be got to hold at all, and the disease was found to have extended through the uterine tissue at a point about the junction of the cervix with the body of the uterus into the tissues and the bladder. While separating this, unfortunately the bladder was torn. The uterus was then removed, and the broad ligaments secured by ligatures.

The patient made an excellent recovery from the operation, but had a vesico-vaginal fistula through which all the urine passed. On April 14th, with the assistance of the same gentlemen, I operated with a view of closing the fistula, and adopted the flap splitting operation as originally proposed by Collis, of Dublin, and later practised by Tait in this country.

The opening was of some size readily admitting the tip of the finger. After separating the vaginal mucous membrane from that of the bladder freely all round, I passed five chromic gut sutures through the vesical portion and inserted the vesical mucous membrane into the bladder and tied the sutures. I then passed five or six deep silkworm gut sutures from the vaginal through the whole thickness of the flaps, entering the needle about three-quarters of an inch from the edges. These were held by catch forceps, which I united the edges of the vaginal mucous membrane by fine silk sutures. These having been accurately adjusted, I finally tied the deep silkworm gut sutures, washed out the vagina with sol. hyd. perchlor. 1-10,000, and dusting in some iodoform, packed the vagina lightly with iodoform gauze. I then tested the bladder by washing it out with warm water, and found all apparently secure.

CASE III.—*Case of Fibroid in Broad Ligament Removed with Uterus per Vaginam.*

Mrs. M., æt. 42, married, sent to me by Mrs. Alden, M.D., of the Mission Hospital, Canning Town, suffering with extreme pain caused by a fibroid situated in the right broad ligament. Has had no family. Slight menorrhagia. Suffered a good deal of pain at periods, as well as excessive pain being nearly always present.

Dr. Margaret Alden recommended that an operation should be performed. This was, however, negatived at the hospital when the patient had applied for relief. February 12th, in consultation with Mrs. Alden, I examined the patient. A slight fullness was only discovered by abdominal examination over the right iliac region; pressure caused a good deal of pain *per vaginam*. The os was found to be healthy. On the right side and slightly posteriorly a hard tumour was discovered fixed to the uterus, which was pushed completely over to the left. The tumour appeared to be somewhat fixed, was very painful on examination, and was situated apparently entirely in the true pelvis.

The patient said she was quite precluded from getting her living owing to the pain.

I quite agreed with Dr. Margaret Pearse and advised operation.

The patient was admitted into the Cancer Hospital, and when under ether was placed in the lithotomy position, and I tried in the first place to remove the tumour by opening up Douglas' pouch and the broad ligament, hoping to be able to enucleate the tumour. I found, however, this was not practicable, so I then decided to remove the uterus as well. This was very difficult, owing to the space occupied by the tumour. I, however, divided the broad ligament in segments on the left side, and then drew the uterus out, and then was enabled to enucleate the tumour and ligature the broad ligament.

The patient made an uneventful convalescence, and is now quite well.

CASE IV.—*Abdominal Hysterectomy for Sloughing of the Uterus.*

Mrs. G., æt. 58, was sent to Dr. Clement Godson by Mr. Baker, of Waterloo Villa, Hants, in the early part of February, suffering from a foul-smelling discharge. From the condition of things which Dr. Godson found he asked me to see the patient with him with a view of deciding if it was a suitable case for recommending an operation.

On February 24th, Dr. Godson and myself examined the patient. By abdominal examination a large tumour was readily felt occupying the lower part of the abdomen, movable, no pain or discomfort. It was composed of two large bosses, which were situated in either corner of a much enlarged uterus.

Per Vaginam.—The os was felt to be open and smooth, and, from all appearances, healthy. Bimanually the tumour was evidently incorporated with the uterus the whole of which was freely movable. By examination with speculum a dark-coloured stinking discharge was seen pouring from the os. The sound was introduced but could not be passed for more than three inches.

Patient said she had been quite well until June, when she first noticed a discharge; this gradually increased and became very offensive. She has had no family. The patient has a sallow, unhealthy appearance, a very quick small pulse, and a persistent temperature of from 101° to 102°. The diagnosis arrived at was a sloughing fibroid of the uterus, and an early operation was recommended.

On February 27th, with the valuable assistance of Dr. Clement Godson, Mr. Leaf and Mr. Brown giving the anæsthetic, I operated, performing subperitoneal hysterectomy. There was no difficulty in the operation which the patient bore well. She was troubled, however, afterwards, with persistent vomiting, which lasted several days. The temperature the day after operation dropped to 99°, but the pulse remained very rapid, viz., 132 per minute. There was a good deal of distension, ordered grs. v. calomel, and large turpentine enema, and to be fed entirely *per rectum* with beef tea and brandy, and and zymised suppositories.

March 1st.—Vomiting continued. Bowels not relieved. The calomel and enema were repeated with but little or no effect. On the 2nd a dose of castor-oil was given but still no action, the distension being very great. The temperature, however, remaining normal, but pulse very quick, and tongue furred.

3rd.—Flatus passed during the night, and bowels slightly relieved after enema, vomiting not so persistent. Distension still great.

Ordered $\mathfrak{Mj}$ doses of nux vomica, and $\mathfrak{ss}$ doses of Dinnefords magnesia every four hours.

4th.—Still no action of bowels, more than slight discolouration of the enema.

5th.—Bowels freely opened, patient from this point rapidly improved.

On 20th a considerable quantity of pus was seen escaping from the os, and on examination a large slough was withdrawn and one of the sutures, which were used for suturing the cervix uteri. The discharge still continued, and four days later I removed another long slough and another suture. From this point the patient convalesced well, and returned home a month after the operation.

THE EFFECTS OF BADEN-BADEN MINERAL WATERS ON THE WOUNDED.

By Dr. W. H. GILBERT,
Baden-Baden, Germany.

As the Grand Ducal Government is making a great reduction in the prices of all their hydro-therapeutic procedures, baths, &c., for officers and soldiers wounded in South Africa, and all private sanatoria and hotels in Baden are following their example, I think it may not be out of place to give a few details regarding the nature of our mineral waters and other means of cure, and also a few statistics of the results obtained here after the war of 1870-71.

Baden's hot springs (66° C.), about 20 in number, emanate half-way up the Castle hill on the south side. The source of these springs is supposed to be situated 1,500 metres deep in layers of granite. The latest analysis of the components contained in the springs gives the following results:—

Bicarbonate of protoxide of iron	0.0199
Bicarbonate of protoxide of manganese	0.0435
Bicarbonate of magnesium	0.1135
Bicarbonate of calcium	1.7290
Sulphate of strontium	0.0445
Sulphate of calcium	2.1769
Chloride of potassium	1.2830
Chloride of sodium	20.2670
Chloride of calcium	0.2690
Chloride of lithium	0.5818
Chloride of rubidium	traces
Chloride of calcium	0.0129
Chloride of magnesium	0.0887
Bromide of magnesium	0.0471
Phosphate of calcium	0.0029
Arsenate of calcium	0.0064
Silicic acid	1.2671
Free carbonic acid	0.1192
Organic substances	traces

According to the above analysis a quart of water contains 58 milligrammes of chloride of lithium, a very large quantity as compared to other mineral springs. The two other important components are arsenic and chloride of sodium. The Baden mineral water contains 0.24 milligrammes per quart of the former and 2.0269 grammes per quart of the latter.

The three bathing establishments, the Grand Ducal Friedrichsbad, for gentlemen, the Grand Ducal Augustabad, for ladies, and the Landesbad (destined

for poor people, kept at the expense of the public relief funds, and for people of small means, who board there at their own expense) are considered to be the finest on the Continent. They stand on the spot where the Romans had their baths. These bathing establishments contain hot baths, cold baths, electric baths, "Wildbader" (warm baths with permanent in and out flow of water), and magnificently arranged Turkish baths. Furthermore, the Grand Ducal Government has arranged this year in both bathing establishments Tallerman's treatment with superheated air, and also the Italian fango (volcanic mud) baths, the mud for which is procured from Battaglia.

In each establishment we find an immense room fitted up for the use of mechanical gymnastics (Swedish mechanical gymnastics) according to the principle of Dr. Zander, of Stockholm.

Apart from the economical side of the question (30 times for 30 marks—30s., or a yearly ticket for 300 marks—£15) the mechanical gymnastics are much better than the natural ones. In the first instance they permit of an exact limit of the movements by screws and levers. Each apparatus can be so arranged that the prescribed movements go to a certain point and no further. One can also arrange the apparatus so that the movements become gradually more difficult. In the second place they allow the resistance for each single movement to be exactly determined through weights, which, similar to those on decimal scales, are moved by a lever, and gradually increase the muscular exertions, according to the strength of the patient.

Many apparatus have also very exact counting apparatus, so that there is no doubt as to the number of prescribed movements. Free will is entirely excluded by this method. This form of gymnastics, combined with carefully chosen diet, exercise accommodated to the condition of the patient, suitable bathing procedures and massage, form the nucleus of the so-called "Nauheim treatment," which becomes more popular in Baden each year, and is applied with increasingly good results.

Between the Friedrichsbad and Landesbad a large and admirably arranged inhalatorium has been erected for inhaling all kinds of mineral waters and various medicinal substances.

Besides the three bathing establishments a number of the hotels have mineral baths.

The mineral waters are internally and externally applied, but their external application will alone be discussed in this brief article. They are applied as full baths, local baths, and as douches.

Patients remain in the bath from a quarter to one hour, and the temperature varies, according to the nature of the case from 32 to 38° C.

The mineral water douches are either applied cold, tepid, or hot, in the form of a jet or shower. The strength of the jet is varied according to the state of the patient.

The mineral waters of moderate temperature have a soothing effect on the peripheral nervous system, the patients feel comfortable in the baths and strengthened on leaving them. Sleep becomes calmer, all bodily functions are improved. The baths do not at first suit persons with weak and excitable nerves; such patients feel tired after bathing, are more excited, and often complain of giddiness, sleeplessness, and poor appetite. But if the case is properly conducted, and the patient only bathes every two or three days, does not remain too long in the bath, and care is taken that the temperature is moderate, these symptoms generally disappear in a short time, and we have seldom seen a case where the baths had to be given up.

In cases where the baths cause abnormal excitement, it is of especial importance that the patient should rest after bathing. The effect of alternate rest and movement, especially if the diet is strengthening and

the climate healthy, is generally very favourable, calms the over-excited nerves, regulates the disturbed circulation and accelerates the re-establishment of the decreased strength.

The effect of the mineral water on wounds is in the first place the thorough cleansing of the same. To begin with wounds are locally irritated through the salt and the warmth of the water, the granulations become fresher through the stimulating effect on the action of the vessels and nerves, the suppuration healthier, while the inflammation, swelling and induration in the vicinity of the wounds diminish. Fistulous canals become soft and are more quickly healed. Hard firm filiform cicatrices, which so often impede movement, become suppler. Exfoliation of the bones is expedited in consequence of the augmented suppuration. Sequestra, the expulsion of which usually takes such a long time in hospitals, become more quickly isolated in consequence of the stimulating and irritating effect of the mineral waters. Foreign bodies left in the wounds such as bullets, remains of lead, bits of cloth, bits of leather, are also expelled more quickly because of the accelerated process of ulceration and healing.

The Baden waters have a specially good effect on induration, exudation, and stiffness in the joints consequent on wounds and inflammations of long duration contusions, &c. In these latter cases the douches are a useful adjunct to the baths.

The accelerated circulation of the blood, the locally increased action of the skin, in fact, the increased vitality of all the affected parts produced by the douches, aid the baths considerably in their action of absorption and resolution of these before-named inflammatory products.

Our mineral waters have been most frequently employed in cases of chronic articular and muscular rheumatism, and their sequelæ, and the results have been most satisfactory.

An excellent accessory to the mineral baths are the splendidly fitted up vapour baths and Zander's Swedish gymnastics. The necessary steam for the vapour baths is supplied by the natural vapours emanating from the hot mineral waters. These baths can be applied locally or in the form of Turkish baths. (In the former case the part to be treated is placed in a kind of box, the head always being free.)

The soothing warmth of the steam, its exhilarating influence on the nervous system, the accelerated effect on the circulation and the respiratory organs, and the profuse production of perspiration are to be considered as the chief peculiarities of these baths.

The local vapour baths are useful in cases where the patient is too weak to bear the more energetic action of the Turkish baths with their subsequent procedures of cold baths, massage, and douches.

Obstinate rheumatism, neuralgia, gout, paralysis, induration of the cicatrices and muscles, are chiefly treated with steam, and it is evident that heat must exercise in all its applications a beneficial influence in cases of stiffness of the joints, of callous, fistulous canals and cicatrices.

The mineral waters are also used for inhalations in cases of chronic inflammations of the mucous membrane of the nose, the throat and trachea.

Taking into consideration the many other advantages which Baden offers in its excellent sanatoria, &c., and well-arranged hotels, its beautiful scenery and mild climate, we need not be astonished at the good results proved by the statistics in next column of patients treated here after the War of 1870-71.

Many of those mentioned in the statistics as improved have no doubt in time entirely recovered.

Out of the 339 cases there are only 16 "without result;" 4 of these cases were incurable, and 4 could not bear hot baths, so that a cure was not commenced.

The cure lasts between 6 to 90 days, the usual

time necessary is 30 to 45 days. Of course this depends on the nature of the illness.

Disease.	Total.	Im- proved.	Cured.	With- out Result.
A—WOUNDED.				
Simple flesh wounds ...	63	31	31	1
Flesh wounds, combined with lesions of nerves or arteries	14	10	3	1
Bone wounds... ..	73	48	21	4
Wounds in the joints ...	17	15	...	2
Gunshot through the ver- tebral column	3	1	1	1
Operations	14	7	6	1
Luxations	2	1	...	1
Contusions	11	2	8	1
	197	115	70	12
B—SICK.				
Rheumatism	106	18	87	1
Neuralgia	10	2	8	...
Paralysis	6	3	3	...
Chronic bronchial catarrh...	3	...	3	...
Tuberculosis	2	...	...	2
Erysipelas and abscess ...	1	...	1	...
Chronic diarrhoea subse- quent to dysentery ...	1	...	1	...
Ulcerations of the glands of the neck	2	...	2	...
Convalescents	11	1	9	1
	142	24	114	4
Wounded	197	116	70	12
Sick	142	24	114	4
	339	139	184	16

Clinical Records.

CASE OF CONGENITAL LARYNGEAL OBSTRUCTION—SUDDEN DEATH FROM LARYNGEAL SPASM—SPECIMEN OF LARYNX SHOWN.

By Dr. C. H. McILRAITH.

THE patient was a female child, æt. 6 months, who had suffered from persistent respiratory stridor since six weeks of age. No other cases of the kind had occurred in the family, and there was no history of injury at birth or convulsions after. The child, however, showed signs of congenital syphilis. The stridor was entirely inspiratory, and was absent during sleep. It was increased when the child's breathing was irregular or deepened as after crying, and also by changes of temperature. There were no signs of obstruction. The mucous membrane of the nose and naso-pharynx was generally relaxed, and there was some small amount of post-nasal adenoids present. On examination of the larynx, the epiglottis was seen to be sharply folded and incurved on itself. The aryteno-epiglottic folds seemed to extend from the tip of the epiglottis to the tips of the arytenoids as thinned bands, which were closely approximated to one another.

Thus the upper aperture of the larynx was reduced to a narrow slit with two small openings, the one at the tip of the epiglottis, and the other between the arytenoids. The thin folds seemed quite flaccid, and flapped to and fro on respiration. There was some slight oedematous swelling over the arytenoids. The child died suddenly two months later, apparently from laryngeal spasm. A post-mortem had been obtained and the larynx was shown. It gave the appearances much the same as seen during life, except that there were evidences of considerable relaxation of the mucus membrane over the arytenoids. The case was brought for-

ward as one of interest on account of the comparative rarity of the disease, the possibly fatal issue, and as confirmatory, by means of post-mortem evidence, of the views put forward by Drs. Sutherland and Lack (*Lancet*, 1897). From the post-mortem appearances it was impossible to consider otherwise than that the stridor was purely mechanical, produced by the valvular action of the upper aperture of the larynx, depending partly on the peculiar malformation and partly on the flaccidity of these parts in infants. If post-nasal adenoids affected it at all, it could only be by rendering the tissues more liable to relaxation, and thus producing still more narrowing of the upper lumen of the glottis.

THE ADELAIDE HOSPITAL, DUBLIN.

Case of Axillary Aneurysm cured by Ligature of the Third Stage of the Subclavian Artery.

Under the care of Mr. FRANCIS T. HEUSTON, F.R.C.S.I.

THE patient, a car-driver, æt. 43, was admitted into the Adelaide Hospital on January 2nd, 1900. In June, 1898, he felt a pain of constant character in his right shoulder, which, with swelling of his arm, caused him to apply for relief at a hospital in this city, where his case was diagnosed as axillary aneurysm. He was admitted into the hospital in November, 1898, and was treated by instrumental pressure until March, 1899, when he left, somewhat relieved, to resume his work; but finding the exposure incidental to his employment was giving rise to swelling of his hand and arm with increased pain, he presented himself for treatment at the Adelaide Hospital. On admission, on January 2nd, 1900, I found the patient a strong, muscular, well-nourished man. Immediately beneath his right clavicle a considerable swelling existed, which occupied this region to the lower border of the great pectoral muscle. This tumour had a well-marked distensible pulsation, and on palpation gave the sensation as if a very thin wall existed; in fact, it felt as if it must soon burst. On auscultation a well-marked bruit was present. On pressure on the shoulder the bruit and pulsation stopped, as did also the radial pulse. On January 11th, 1900, I ligatured the right subclavian artery in its third stage by the usual incision parallel to the clavicle. Considerable enlargement of deep veins and the presence of the lower cord of the brachial plexus in front of the artery gave some trouble in passing the ligature. When the artery was exposed its coats were found to be remarkably attenuated, so much so as to feel more like the coats of a vein than an artery. Owing to this condition the ligature (strong catgut) was only drawn sufficiently tight to occlude the lumen of the artery, as I feared its cutting through if pressure was applied. After the operation the progress of the case to recovery was uninterrupted, the wound healing by first intention. The patient left the hospital on January 31st, 20 days after operation. On examining the patient now, some 12 weeks after the operation, a solid tumour will be found in the axilla without bruit or pulsation. It will also be noticed that no radial pulse exists in the right arm; no swelling or oedema of the hand or arm is present. The patient has perfect use of his arm, and says he has had no pain since the operation; so I may claim that his aneurysm is cured.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, APRIL 27TH, 1900.

Sir R. DOUGLAS POWELL, Bart., President, in the Chair.

CLINICAL EVENING.

DR. NORMAN DALTON on a case of

AORTIC REGURGITANT MURMUR HEARD IN THE PULMONARY AREA.

The patient is a man, æt. 26. The points of interest apart from the physical signs are (1) that the patient

has never had rheumatic fever, and that the endocarditis was undoubtedly due to scarlet fever with nephritis at the age of 14; (2) that the man has remained undeveloped since the scarlet fever, having no hair on the face; (3) that he has been under observation by different observers for three years, and that the physical signs have always been the same. The heart's dulness is enlarged, but does not extend behind the sternum. On auscultation, a diastolic bruit together with a systolic bruit and an accentuated second sound is heard at the third left costo-sternal articulation and not at the right as would be expected. Further, this diastolic bruit is not conducted downwards as it should be if due to aortic regurgitation, but is well heard under the clavicle and all over the back. There is also a diastolic thrill in the situation of the diastolic bruit. Other points of less consequence are that there is a long systolic bruit at the apex, that the spleen is large from infarctions, and that the kidney has never recovered from the scarlatinal nephritis and is now in a condition of contracted large white kidney. The important points concerning the physical signs are, therefore, that there is a diastolic murmur audible in the pulmonary area, that the murmur is not conducted downwards, and that, synchronous with the murmur, there is an accentuated second sound. A diastolic murmur in that position should mean pulmonary regurgitation, probably of congenital origin, particularly as the patient is so ill-developed; but this can scarcely be the case because there is no cyanosis, and we know that the heart trouble dates from the age of 14.

The PRESIDENT said he had seen three cases of mitral regurgitation, in all of which, however, the disease was secondary to mitral stenosis of considerable duration. He asked whether the pulmonary regurgitation had been observed to come on subsequently to the mitral disease, and at what interval. He pointed out that in mitral stenosis splenic infarction was common, whereas it was rare in aortic regurgitation unless of infective origin.

Dr. CHAPMAN thought the loud second pulmonary sound was opposed to the idea of pulmonary regurgitation.

Dr. DALTON pointed out that in his opinion the case was one of aortic, and not pulmonary, regurgitation.

TUBERCULOUS GLANDS IN MEDIASTINUM.

Dr. HABERSHON showed a child in whom he suspected tuberculous glands in the anterior mediastinum. He had sought to confirm this by radiography, but with indifferent success.

Mr. W. H. BATTLE showed a patient from whom he had removed a recurring tumour of the frontal region of carcinomatous character more than two years before with the underlying bone, which had been perforated. The patient, a married woman of 37, was under treatment at the Royal Free Hospital more than two years ago for a recurring tumour of the forehead, the first signs of which had been noticed eight years previously, but the growth for which she required treatment had existed only for two years. The tumour (which was shown to the Society, and is in the museum of the Royal College of Surgeons) measured 4½ inches from side to side, 3 inches from above downwards, and projected 3½ inches from the level of the skin. It was irregular, fungatory, vascular without pulsation, and not covered by skin. It bled freely at times. She was thin, worn, and anxious-looking. Operations had been done in three stages:—1, removal of the very vascular soft growth; 2, removal of the underlying bone, which had been penetrated by the tumour at one point and at other points eaten away; 3, grafting of the dura mater when it had become covered with granulations. Microscopically, the growth is a spheroidal-celled carcinoma. The operation scar is firm without any bone in it, and the patient completely conceals it by brushing her hair so as to cover it. She is in good health and spirits, and six weeks ago gave birth to another child.

CASE ALLIED TO BECKLINGHAUSEN'S DISEASE.

Dr. HARRY CAMPBELL showed a girl who six years ago was admitted into a home with angular curvature. Two years ago had to take to bed in consequence of para-

plegia; the legs are now rigid, and show excessive myotatic irritability, and leading to frequent clonus. Patient is anemic. The glands in the axillæ and supra-clavicular regions are enlarged. In certain regions, but especially in the right humeral region, the right posterior thorax, and to a less extent the left humeral region, are to be felt nodular masses, apparently consisting of hypertrophied subcutaneous tissue. They appear to be somewhat tender to the touch. The skin in these regions is very loose, being most so where the nodular masses are most pronounced. The skin over the right forearm is however, very loose, and here there is a little subcutaneous hypertrophy. The skin is curiously pigmented. The pigment is deposited in patches varying in colour from light yellow to dark brown, and in size from a pin-point to several square inches. It is most marked over the subcutaneous masses. Thus the entire right humeral region is coloured brown; the colour being deepest where the masses are thickest. The trunk is also pigmented, chiefly in the form of minute spots which show a decided tendency to symmetrical arrangement. Thus on the abdomen there are two spots about the size of a florin, one on either side of the middle line above the umbilicus, and a similar spot in the middle line just below the umbilicus. There is practically no pigmentation in the lower extremities. When the patient was first admitted into the Home, the condition described was limited to the right humeral region, which presented much the same appearance as does the left humeral region now, i.e., there was moderate subcutaneous hypertrophy over the triceps, the overlying skin being pigmented. It was not till about a year ago that this latter region became involved. Since admission the disease has steadily advanced. The right hand is congenitally deformed. The third and fourth fingers and their metacarpal bones are fairly normal, but all the remaining phalanges and metacarpal bones are remarkably mobile, as though their several joints were devoid of ligaments, and were not fixed by tendons and ligaments. The hand has a flattened and splayed appearance. The second and third fingers are spindle-shaped. Patient is perfectly intelligent. She reads and does fancy work, though with difficulty owing to the condition of the right hand.

The President entered a protest against the practice of giving to diseases the names of their discoverers, especially at that Society.

Dr. ROLLESTON pointed out that it would be difficult to devise a name for this condition which would embody the principal features of the disease. His view was that the disease belonged to the class of congenital aberrations of the mesoblast, which in some cases affected the deeper structures. He suggested that the case, as in an instance to which he referred, might ultimately degenerate into sarcoma.

Mr. CLEMENT LUCAS referred to a case sent to him by Dr. Abraham. The patient, a woman, æt. 27, had an enormous mass of pigmented loose skin hanging from the buttock to below the knee, and much loose skin extending to the ankle. By a series of operations he had removed the redundant tissue, and she was now nearly cured. The tissue removed contained many large veins, and numerous fibrous growths of nerves. The history dated from childhood, but not from birth.

Mr. H. BATTLE recalled a case which he published in the *Lancet* some years ago in which he had performed a similar operation. The disease resembled what was called "fingers and toes" in turnips. There had been no recurrence.

Dr. CAMPBELL, in reply, agreed that the disease was probably of developmental origin.

Dr. LEDIARD showed a man, æt. 39, from whom a sub-clavian aneurysm had been successfully removed on January 21st. Ligation of the first part of the sub-clavian had been done on April 14th, 1899, without benefit. The first part of the axillary was also tied on August 4th without result. The arm became useless and painful, so that interference was imperative. Two-and-a-quarter inches of the collar bone were removed, prior to the excision of the aneurysm, and the operation only lasted three-quarters of an hour. Recovery of the arm was almost immediate, and the wound healed without trouble. The aneurysm was as large as an hen's

egg, and the undersurface of the clavicle was somewhat worn from pressure.

A BOY WITH (APPARENTLY) TUBERCULOUS MEDIASTINAL GLANDS PRESSING ON THE RIGHT LUNG.

Dr. NORMAN DALTON showed a boy, æt. 12, who was well until five months ago. He has a tuberculous aspect and well marked remittent fever. The physical signs of importance are that there is dullness over the upper half of the sternum, and over the adjacent portion of the right lung. Over the dull area the heart's sounds are very loud, harsh breathing can be heard. Beyond the dull area the upper half of the right lung in front is comparatively dull, while the breathing there is deficient, and the vocal fremitus diminished. The veins over the front of the chest, proceeding from the sternum, are dilated, and when the head is retracted the veins in the neck stand out prominently. There is a rather large and hard gland in the left axilla, and the superficial epigastric veins are a little large, but nothing can be felt in the abdomen. Probably the dullness behind the sternum and the deficient resonance, breath sounds, and vocal fremitus in the upper lobe of the right lung, are produced by a solid mass extending from the mediastinum and compressing the bronchus leading to the upper lobe of the right lung. The tuberculous family history is not positive, and in the last fortnight the physical signs have increased almost too rapidly for tuberculous glands, so that, while it is still most likely that the mass is tuberculous, it is not quite certain that it is so, for sarcomatous or lymphadenomatous growths extending from the mediastinum into the lung, by the side of the bronchi would produce the same physical signs pointing to aortic regurgitation, it may fairly be concluded that the case is one of aortic regurgitation, with the diastolic bruit audible on the left side, instead of on the right. The reason for this abnormal position is probably that the heart as a whole is displaced to the left and kept there by adhesions. These adhesions may be pleuritic, but it is possible that the fixation of the heart may be due to pericarditis and extra-pericardial cellulitis occurring during the scarlet fever and nephritis. The abnormal position of the heart explains the abnormal position of the diastolic bruit, but does not altogether explain the fact that that bruit is not conducted downwards. Still, with the heart too far on the left side, the ascending aorta must be stretched and rendered more horizontal, so that its axis would be more at an angle with the axis of the left ventricle, a fact which would certainly prevent conduction, and possibly divert it towards the back.

Dr. CALEY thought the dullness might not improbably be due to lymphadenoma and asked if large doses of arsenic had been tried.

Dr. WHITFIELD suggested that an examination of the blood might assist in the diagnosis and added that a rise of temperature was exceptional with tuberculous glands.

Dr. HABESHON thought part of the dullness might be due to condensed lung. He had seen a temperature in association with tuberculous glands.

Dr. T. D. SAVILL exhibited a case of

MACULAR LEPROSY, IMPROVING UNDER CHAULMOOGRA OIL.

The patient was an intelligent lad, æt. 14, born in Demerara. He had left that place and come to England at the age of 11. The disease began when he was 10 with erythematous and pigmented patches slightly raised scattered in different parts of the body, for the most part symmetrically distributed. The patient said that he had been unable to feel in most of these patches, and he had had other places where there was no pigment or erythema which were also without sensation. The patient's skin was inclined to be a little dark, and he presented the appearance of a half-caste. At the present time there were scattered over the arms and legs a series of ovoid, slightly pigmented areas. These areas were quite flat and presented no alteration in texture at the present time; but in many of them the pigment was rapidly disappearing. Both the ulnar nerves (but especially the left) were thickened; they had previously been more so. The chief interest of the case lay in the administration of chaulmoogra oil. The patient had taken this remedy for nearly a year in gradually

increasing doses, beginning with 12 drops daily, until now he was taking 100 capsules, each containing four minims of the oil, per diem. The swelling and erythema had entirely disappeared, and the pigment was fast disappearing. No anæsthesia could be anywhere made out, and the ulnar nerves were decidedly less thickened than they used to be. These immense doses of the remedy did not upset either the digestion or the general health of the patient.

COMPLETE REMOVAL OF CLAVICLE.

Mr. CHARTERS SYMONDS showed a man, æt. 47, whose entire clavicle he had removed for sarcoma in February, 1899. The movements of the arm were perfect. The growth proved to be a spindle-celled sarcoma.

NEW GROWTH OF BASE OF SKULL WITH PARALYSIS OF NERVES.

Dr. PERCY KIDD showed an elderly woman with a new growth on the base of the skull which was associated with unilateral paralysis of the 1st, 2nd, 3rd, 4th, 5th, 6th, and 12th cranial nerves.

UNILATERAL PARALYSIS OF SOFT PALATE.

Dr. ST. CLAIR THOMSON showed a man with one-sided paralysis of the soft palate, probably of diphtheritic origin. Six weeks before he had been laid up with "double quincy," and three weeks later fluids began to regurgitate through the nose. He now presented paralysis and anæsthesia of right side of palate. The interest of the case lay in the unilateral character of the lesion, a very uncommon feature in palatal paralysis of diphtheritic origin.

ANEURYSM OF THE SUBCLAVIAN ARTERY.

Mr. J. HUTCHINSON, jun., showed a man, æt. 47, with aneurysm of the subclavian artery. He had syphilis 15 years ago and was treated for seven weeks with mercury. Eighteen months ago he noticed pain on the left side of the neck on turning his head, then a throbbing swelling over the collar bone on the left side. Treated by a doctor for 18 months with iodide of potassium up to 40-50 grains daily. He complained of pain down the arm with numbness in the fingers, and had attacks of dizziness. Small expansile tumour above the inner third of the clavicle, stationary, not adherent to the skin, with a distinct bruit on auscultation. Pulse on the left side is delayed as compared with the right. Tension about the same. Left carotid tension is distinctly less than that on the right. The subcutaneous veins on the left side of the chest are dilated. The circumference of the arm on the left side is two inches more than that on the right. Clubbing of the fingers is marked in the left hand.

Mr. CHARTERS SYMONS suggested that it might be operated upon if only one could make sure of the condition of the vessel beyond the aneurysm.

Mr. STANLEY BOYD remarked on the large proportion of these aneurysms which remained stationary or underwent spontaneous cure. In the absence of further enlargement or other symptoms he urged that one might well hesitate to operate.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF SURGERY.

MEETING OF FRIDAY, MARCH 30TH, 1900.

The President, Mr. R. L. SWAN, F.R.C.S.I., in the Chair.

Mr. JAMESON JOHNSTON described a case of inter-scapulo-thoracic amputation for sarcoma.

Mr. SWAN referred to the case of a nurse who developed a myeloid sarcoma growing from the great tuberosity. In the performance of her duties she fractured her arm through the surgical neck. He removed the humerus at the joint, and as it was noticed that the capsular muscles were engaged, the supra-scapular muscle and the tendons inserted into the humerus were also removed. She remained well for 18 months, when the tumour returned, and Mr. Watson Cheyne removed the scapula and a portion of the clavicle. Her future, however, was doubtful.

Mr. JOHNSTON, in reply, said that if recurrence took place he would give up all hopes of removing sarcoma without recurrence. The tumour was a periosteal sarcoma.

Mr. F. T. HEUSTON read note of a case of Axillary Aneurysm, which will be found under "Clinical Records."

In discussing the case,

Mr. BENNETT said the sounds audible in the tumour were of such a nature that if heard behind the sternum the question would at once arise whether the man had not aortic aneurysm.

Mr. LENTAIGNE observed that he could hear no heart sounds or murmur of any kind over the tumour.

Dr. DOYLE said, on examining the patient, he felt what he thought was pulsation in the tumour. He did not hear any murmur. He believed the impulse was not in the tumour itself, but came from some of the vessels behind it which had undergone compensatory enlargement.

Dr. KNOTT asked if the man was suffering now, or had suffered previously from albuminuria.

Dr. GOULDING asked if there was a history of syphilis in the case?

Dr. TRAVERS SMITH said he could not hear the heart sounds over the tumour. On listening towards the edge the pulsation of the carotid could be heard.

Mr. JOHNSTON asked what was the thickness of the catgut used, and was more than a single strand employed? He was glad Mr. Heuston approved of simply approximating the coats of the artery.

Mr. HEUSTON, in reply, said he was unable to detect any sound over the tumour. As to the condition of the kidneys before operation, the urine was found to be of sp. gr. 1026, acid reaction, no albumin, no sugar, or deposit. There was no history of syphilis. The catgut used was the thickest variety ordinarily employed in hospital operations. He did not rupture the internal and middle coats because the wall of the artery was too thin. Although it was now laid down that there was no necessity to rupture these coats, still he felt easier in his own mind by rupturing them where admissible.

TUBERCULOSIS OF ANKLE AND FOOT.

Mr. JOHN LENTAIGNE exhibited a case in which extensive tuberculous disease of old standing, involving the ankle-joint and foot, with caries of the os calcis, astragalus, and lower end of the tibia, and fibula, with numerous septic sinuses, had apparently been cured by a thorough scraping with Volkmann's spoon, followed by disinfection with chloride of zinc and absolute phenol. This operation had been performed four months previously, when the patient was in a very bad condition, much wasted and suffering greatly from pain. Since then the limb had been kept in plaster of Paris, and the improvement in the patient's condition had been continuous and uninterrupted. The temperature had fallen to normal at once, and remained normal. The girl was now, as everyone could see, fat and strong, and she believed herself to be cured. The plaster of Paris had only been removed the day before, and consequently the girl walked stiffly and with a limp. The scraping operation had been done without much hope of a cure. It was intended as a cleansing preliminary to amputation or osteoplastic resection of the foot, but the result had been so very satisfactory that Mr. Lentaigue had thought it worth while to exhibit the case. At the operation the bones mentioned were found to be extremely soft, and much debris was removed; nearly the whole of the astragalus had come away.

Mr. SWAN said he had seen a great deal of tuberculous disease of the ankle, and he felt very doubtful of successful treatment. The anatomical arrangement of the joint made it very difficult to know when all diseased material was removed. The case was undoubtedly very much improved by the treatment, but he should like to see it at the end of twelve months.

Mr. BENNETT said he could not regard the joint as healthy, because its temperature was above normal. A point in favour of recovery was that so many sinuses had healed.

Dr. KENNAN said he was struck with the extraordinarily rapid and ready way in which the second

septic infection was controlled after the procedure adopted, and he thought the joint was now in a position to get well of itself.

Mr. LENTAGNE, in reply, said the limb was now being used for the first time in two years, and had only then been taken out of plaster. It was, therefore, not strange that the limb should feel warmer to the hand than the other one. He did not believe that all the tuberculous material was removed in excision of the hip or knee, yet these cases nearly always get well, especially knee cases. Tuberculous disease was often very amenable to partial surgical operation. In this case he believed a cure had been effected. All the numerous sinuses had been healed completely and satisfactorily, and now presented the dimple or depression which usually indicated a permanent cure; there was neither pain nor tenderness in the joint nor near it. As Mr. Swan was doubtful about the permanency of the cure, he intended, if at all possible, to exhibit the case again after 12 months.

The Section then adjourned.

BRITISH GYNÆCOLOGICAL SOCIETY. MEETING HELD THURSDAY, APRIL 19TH, 1900.

The President, Dr. W. J. SMYLY, in the Chair.

SPECIMENS.

Mr. F. BOWREMAN JESSETT showed the following specimens:—(1) Two uteri removed for carcinoma of the cervix; (2) Two myomatous uteri removed, the one by vaginal and the other by abdominal hysterectomy. Notes of these will be found on page 444.

Dr. J. MACPHERSON LAWRIE (Weymouth) referring to Mr. Jessett's question as to the best time at which to operate when the bladder was accidentally injured during hysterectomy, said that he had himself cut into the bladder in several difficult cases. He had usually repaired the rent at the time, but occasionally later. He had always found that they healed up very quickly. His plan was to denude the edges first. In one case he had got assistance from dilating the urethra and working with one finger in the bladder.

Dr. WILLIAM WALTER (Manchester) said that the question of the best time at which to repair bladder injuries was a very important one. In the few cases that he had been unfortunate enough to meet with, he had always repaired the rent at the time; and as long as the bladder was sufficiently separated from the uterus, so as to get space for working, there was no difficulty. He had found no necessity for paring the edges of the tear, when recent. With regard to the use of the catheter in such cases, the practice at St. Mary's Hospital, Manchester, was to introduce a self-retaining catheter; this was removed and washed two or three times a day, and the bladder was washed out three to four times a day with boric lotion.

Dr. J. H. DAUBER related a case of carcinoma of the cervix, on which he had operated two years ago. The growth filled up the pelvis, and at the first operation he removed the vaginal part of it. At the second operation he tore the bladder, and postponed the removal of the uterus in consequence. He had no difficulty in suturing the rent at the time, and he left in a catheter for two weeks. At the end of this time he feared that the growth might be invading the bladder wound, so he removed the uterus. At the time of the accident about two pints of urine came away, although the nurse in charge had withdrawn 24 ozs. of urine immediately before the operation. The patient remained well till lately, and he was now afraid that she had an inoperable recurrence.

Dr. HEYWOOD SMITH thought it was better to simply pass a catheter three to four times a day rather than put in a self-retaining catheter, removing it twice daily. He thought that the latter plan involved more risk of cystitis.

The PRESIDENT said there seemed to be a general agreement that it was better to operate on a bladder-injury at the time of the accident. But if this were not done it was to be remembered that most cases of this accident healed up very readily and spontaneously.

Mr. BOWREMAN JESSETT, in reply, said that he was very glad to hear the results of these operations in the practice of the Fellows of the Society. The reason he did not sew up at the time of the accident in his own case was that the tissues were rotten. He agreed with the use of the self-retaining catheter after the operation; but he did not see any necessity for separately washing the catheter and washing out the bladder several times a day; it was usually sufficient to wash out the bladder through the catheter.

CYSTO-SARCOMA OF THE OVARY.

Dr. MACNAUGHTON-JONES reported that the ovarian tumour which he had exhibited on the last evening had been examined microscopically by Mr. Targett, and that it had proved to be a spindle-celled sarcoma, the upper portion of which had softened and degenerated into a cyst. The tumour was of an unusually large size for sarcoma of the ovary to attain to. The patient made an excellent recovery.

NODULAR SALPINGITIS.

Dr. MACNAUGHTON-JONES exhibited the adnexa removed from a multipara æt. 39. Both ovaries were cystic and adherent. The Fallopian tubes presented the typical appearance seen in nodular salpingitis, characterised by considerable thickening of the tubes with muscular degeneration, obliteration of the lumen, and nodular enlargements in parts. In this case the tube was directly continuous with the muscular structure of the uterus. The ligature cut the tube completely across. Hemostasis was secured by passing catgut ligatures through the cornu of the uterus at either side. There was not in this case any history of gonorrhoea, and careful examination of the tubes failed to detect tubercle. The patient had done well.

DEGENERATING FIBRO-MYOMA.

Dr. MACNAUGHTON-JONES also showed a large uterine fibro-myoma removed from a patient, æt. 42. He had seen the case five years previously, and then advised palliative treatment, as there were no urgent symptoms, and the tumour was principally intra-pelvic. On seeing the patient again recently the tumour reached to the umbilicus and its pelvic portion had enlarged. The patient was in perfect health, but seeing the increase of size of the tumour, the prospect of easier delivery of it, and also anticipating degenerative changes in it, he advised removal. The tumour was removed by supra-vaginal hysterectomy, and the patient has made a perfect recovery. On opening the tumour, the abdominal portion was found to contain a large degenerating mass in its centre, and to be attached loosely to the pelvic portion, which was an enlargement of the uterus proper, the cavity being greatly distended, and filled with mucoid fluid, the Fallopian tubes being also much enlarged, and surrounded by the fibroid growth. The case was one typically illustrating the advantage of operation, even though a patient were in apparently perfect health, and when increase in growth was the principal indication for interference.

The PRESIDENT showed three specimens of uterine myoma removed by pan-hysterectomy, two of them being removed by the abdominal route and one through the vagina.

In the discussion on the specimens of myoma shown by Mr. Jessett, Dr. Macnaughton-Jones, and the President, Dr. F. EDGE (Wolverhampton) remarked that two of the operators had adopted the method of supra-vaginal hysterectomy, while the President had practised the plan of pan-hysterectomy. In view of the fact that some of these supposed myomata turned out to be in reality sarcoma, he did not think that the leaving of the cervix was justified, especially as no one could tell beforehand whether the tumour would turn out to be sarcomatous or not. To leave the cervix infringed the surgical rule that whenever possible the whole of an organ affected with malignant disease should be removed.

Dr. MACNAUGHTON-JONES asked whether Dr. Smyly had employed Doyen's *pincers hemostatiques*?

The PRESIDENT stated that he had done so in one of his three cases.

Dr. MACNAUGHTON-JONES asked the President to tell them his opinion of the value of this plan of hæmostasis. He proceeded to remark that it would be very interesting if every Fellow of the Society who used these lever forceps would report his results, for Doyen's more recent operation of hysterectomy consisted essentially in the employment of the forceps. Doyen's operation had been practised in Vienna, in Berlin by the Landaus, and in other places, but not much, as far as he has heard, in England. He thought that British operators preferred to still resort to the ligature.

Dr. MACPHERSON LAWRIE remarked that Doyen's assistant, Dr. Warden, had told him that Doyen always used the ligature in addition to the hæmostatic forceps.

Dr. WILLIAM DUNCAN said that the specimens shown formed a very interesting series. With regard to Mr. Jessett's specimen of myoma in the broad ligament, it seemed to him, looking cursorily at the specimen, that the myoma might have been removed and the uterus left. He would like to ask Mr. Jessett how he dealt with the cavity that remained after the enucleation of the tumour. He had had several cases in which there had been such a cavity, and had, as a rule, been able to close it up altogether by the use of a silk suture. Up to the present time he had had 68 cases of intraperitoneal hysterectomy, an account of which would appear in the current number of the *Lancet*. Of these cases, four had died; one of the four had so far recovered that she was about to leave the hospital; and while eating her dinner one day she suddenly fell back dead, from embolism. This death was not consequently attributable to the operation; and he might reckon his mortality at three in 68, or 4.4 per cent. He did not agree with Dr. Edge that they ought always to do panhysterectomy; for in the vast majority of cases they had to do with a true myoma, and not with sarcoma. Personally, he preferred to leave the vagina unopened whenever this was possible. As regards the indications for hysterectomy, there were three classes of cases where interference was urgently required; first, when there was much hæmorrhage; secondly, when the patient suffered from pressure symptoms; and thirdly, when, even in the absence of marked symptoms, the tumour was growing rapidly. He was not personally acquainted with Doyen's operation; but he was so well satisfied with the results of intraperitoneal hysterectomy, that he was but little disposed to make any change. With regard to Dr. Macnaughton-Jones's case, he considered it was typically a justifiable one for operation.

Dr. HERBERT SNOW took exception to Dr. Edge's statement that these myomata were next door to sarcomata. The malignant degeneration of these tumours was quite exceptional, certainly not more than about 5 per cent. It was true that at the time of operation they could not tell whether a growth was sarcomatous or not, but they could at least form an idea, from clinical features, whether it was malignant. If the cervix only was left, he could not see that there could arise any danger from the return of myomata; so it did not seem to him that the small risk of malignancy rendered it worth while to incur the increased risk of danger to the ureters involved in panhysterectomy. He would like to ask Dr. Macnaughton-Jones what means Doyen adopted to check hæmorrhage during the operation, and also what were the results of Doyen's operation as regards mortality.

Mr. BOWREMAN JESSETT, in reply to Dr. Duncan, said that the operation for the intraligamentous myoma was done through the vagina; he first tried to enucleate the myoma, but was unable to do so, so he had to remove the uterus. No cavity remained after the removal of the tumour. He was formerly much in favour of panhysterectomy, in the introduction of which into England he had some share; but he had now come to the conclusion that for most cases supra-vaginal hysterectomy was safer and quicker. He would like to ask Dr. Edge how many cases he had seen of recurrence after supra-vaginal hysterectomy? [Dr. EDGE: Five.] He thought that the operation indicated depended on the length of the cervix; when this was long he preferred supra-vaginal hysterectomy, but if the cervix were short, a panhysterectomy might be better. As regards the results of Doyen's operation, he had seen that eminent surgeon

operate on four cases in Amsterdam; but of these, two, if not three, died.

The PRESIDENT, in reply, said that by "Doyen's operation" he did not understand any one method of hæmostasis; but rather the plan of opening first the posterior fornix, and then drawing up the cervix, which would be found to shell out very easily from its bladder connections. In this process the uterine arteries were separated from the cervix, until they could be secured in the upper portions of the broad ligament, where they became very small, instead of at the base of the broad ligament, where they were large. Moreover, they could then be secured close to the ovarian vessels, so that one ligature would suffice for both. He considered that Dr. William Duncan's results were very good; and if he could show a mortality of only three in 68 cases, he should recommend him to adhere to his present method of procedure. For his own part, he had had very good results from panhysterectomy.

Dr. R. P. R. LYLE (Newcastle-on-Tyne) showed some uterine dilators, which he had had made on the plan of Kelly's urethral dilators. They differed from most dilators of this type in the fact that the graduation of the various sizes was very gradual. This facilitated the operation in cases where the uterus resisted dilatation.

The Secretary read a paper by Dr. RALPH WORRELL, of Sydney, N.S.W., on "Pregnancy complicated by Uterine Myoma and Ovarian Cyst."

Dr. J. INGLIS PARSONS read a paper on "The Parasitic Theory of Cancer as a Basis for Treatment."

[We hope to have space for these two papers, with the discussion, in our next.]

HARVEIAN SOCIETY OF LONDON.

MEETING HELD THURSDAY, APRIL 19TH, 1900.

MR. PEYTON T. B. BEALE, Vice-President in the Chair.

Dr. LAMBERT LACK showed a curtain ring which he had removed from the pharynx of a child, æt. 9. The ring was swallowed at nine months of age, and produced violent fits of coughing and choking which soon passed off. For years the ring had caused no symptoms. The upper edge was free in the post-nasal space, the lower part lay free behind the arytenoids, while the two sides were firmly embedded beneath the mucous membrane of the lateral pharyngeal walls. The ring was cut through with bone forceps at its lowest point, opened out and pulled upwards until free. Dr. Lack emphasised the importance of the coughing and choking attacks following a history of swallowing a foreign body, attention to which would lessen the number of these cases which have been over looked.

Dr. MCLLEITH read notes of a case of Chronic Pharyngeal Obstruction which we publish under "Clinical Records."

Dr. HERBERT TILLEY pointed out that Avellis (Frankfort) had stated that in some case congenital laryngeal stridor was due to pressure on the trachea by an enlarged thymus gland and breathing was at once relieved by removing portions of the gland or stitching it forward to the sternum, or by inserting a tracheotomy tube with a long cannula, which would reach beyond the obstruction.

Replying to Dr. Tilley, Dr. MCLLEITH stated that the thymus gland was of usual size, and that in a case he had seen of pressure on the trachea by an enlarged thymus, the character of the stridor was quite different, and was both inspiratory and expiratory, chiefly expiratory.

Dr. LACK said the specimen was an extremely interesting one to him as it was a further proof of the correctness of the views Dr. Sutherland and he had expressed as to the pathology of this disease, and quite fatal to the hypothesis of those who had ascribed the disease to adenoids.

Dr. HERBERT TILLEY showed a large cholesteatoma which he had removed from the mastoid antrum of a boy, æt. 14. The main symptom was an intractable purulent discharge from the auditory meatus. On

examination a small mass of granulations was seen at the inner end of the posterior meatal wall, through which a curved probe could be passed into a large cavity in the mastoid. The ordinary radical operation was performed, and the whole mastoid process was found to be hollowed out so that no cells existed, while posteriorly the situation of the lateral sinus was easily seen. The bridge of bone between the attic and antrum was removed, the large cavity disinfected with pure carbolic acid, and then packed with iodoform gauze; the wound was completely stitched up at the close of the operation. The patient made an uneventful recovery. The masses when freshly removed were of a pearly lustre externally, and were made up of layers of epithelium, so that they somewhat resembled an onion. Cholesterol crystals could be found in them, and this fact, combined with the waxy nature of the epithelial layers, possibly accounted for the name given to the condition. Dr. Herbert Tilley could offer no satisfactory explanation of the pathogenesis of the cholesteatomata.

Dr. ALFRED EDDOWES said he believed the change in the epithelium thrown off was waxy. He supposed the mother of pearl lustre was due to the same cause as in the case of the little pearl of milium in the skin. He was inclined to theorise that the changes taking place in the mastoid cells were slowly inflammatory, probably on account of the micro-organisms being checked in their growth by the accumulation of their products. The bacteriology of discharges from the ear and other orifices of the body was of great interest, as such discharges frequently set up and maintained skin eruptions.

Dr. SIDNEY PHILLIPS showed a case of a man suffering from bradycardia. The pulse rate frequently fell to 30 per minute, and was practically unaffected by drugs.

Dr. Guthrie, Dr. J. Broadbent, and Mr. Jaffrey discussed the case, and Dr. PHILLIPS replied.

Mr. STANSFIELD COLLIER showed a case of intra-uterine injury to skull, and a case of congenital dislocation to hips.

The cases were discussed by Mr. Peyton Beale, and Mr. Ed. Roughton.

Mr. HUBERT C. PHILLIPS showed a case of hypospadias with complete absence of urethral aperture. On the second day after birth Mr. Phillips made an incision at the apex of the glans penis, and after some difficulty succeeded in passing a probe into the urethra. The aperture was very small, but would be enlarged later. There was absolutely no opening elsewhere in the urethra. Urine had passed normally since the operation.

Mr. JAFFREY considered this case one of the first degree, as the corpus spongiosum was well developed, and that only some slight plastic operation was necessary to relieve the binding down of the penis to the scrotum. As the meatus is very small dilatation would be beneficial.

In answer to Dr. Eddowes, Mr. PHILLIPS stated that there was no specific history with the case.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, April 23th, 1900.

THE PYRETIC TREATMENT OF TYPHOID.

IN the St. Petersburg *Med. Wochens.*, Dr. Kramer has an article on this subject. He looks upon the fever as an important therapeutical factor, the principal effects of which are: To diminish the vitality and virulence of the bacilli; to heighten the resistance of the tissues by heightened leucocytosis and modification of tissue change which render the soil unsuitable for the bacilli. From this standpoint of the therapeutical value of the fever the author has abstained from the employment of antipyretics, and carries out his treatment in the following manner. When the case comes under treatment in the first week of the disease he gives 0.3 grms. of calomel to adults, then the powder every day for three days in com-

bination with a teaspoonful of magnes. sulph.; then 0.003 to 0.002 grms. of calomel for three to five days, to the 15th day of the disease, which is then stopped in view of possible intestinal hæmorrhage. Its place is now taken by naphthaline, grm. 0.5 to 0.3, if the diarrhoea is excessive, or bismuth subnit. If the stools are now liquid, salol is given, and in the course of the fourth week tannigen, grm. 0.2 twice daily. In cases of severe headache the ice-bag is used, and in general no cold baths nor cold spongings. The author lays great stress on careful dieting, in the course of which two indications must be fulfilled: 1. The best substitute must be given for the albumen used up in the fever. 2. The food must be most easily digested, and must not irritate the bowel, either chemically or mechanically. During the first two weeks bouillon, barley or oat starch, eggs, milk, strong wine, a wineglassful five or six times a day, when the heart's functions are normally performed, more when there is sign of weakness, as the impulsive power of the heart is of great importance for many reasons. The condition of the kidneys must be carefully watched. In the third and fourth week food is given sparingly, generally nothing but Knorr's oatmeal, wine and brandy, and egg mixture. In order to prevent hypostasis of decubitus, the author has the back, elbows, and shoulder-blades rubbed with spirit, and the posture changed frequently. The method of treatment described has been followed in a series of 102 cases, with decided shortening of the course of the disease, his results being that the disease ran a two weeks' course in a fourth of the cases, about a three weeks duration being the usual period, and a four weeks very rare. As a rule the first symptoms had all subsided by the 17th or 19th day.

THE 18TH CONGRESS OF MEDICINE.

The 18th German Medical Congress was held in Wiesbaden from the 18th to 21st of April.

Prof. v. Jachsich, of Prague, delivered the first address on the Medicine of the 19th Century, concluding with its future prospects. After speaking of the outbreak of small-pox that characterised the beginning of the century, the war fury of Napoleon, and typhus, and later the cholera, he passed on to characterise the pillars of scientific medicine that were erected during later years, according due praise to the labours of Rademacher, Schwann, Virchow, Bichat, Rokitansky, Arnold, Müller, Brücke, and Helmoltz. The latest child of science was bacteriology. In 1837 proof was first adduced that silkworm disease was due to a fungus. Shortly after Schönlein discovered the fungus of favus. Semmelweis declared that childbed fever was conveyed to patients by dirt and the hands of medical attendants. Henle already taught the contagium vivum, until in 1855 proof was forthcoming that anthrax was caused by organisms. Then in 1873 Obermeyer found spirilli in the blood in remittent fever. These were only the broken stones with which the great structure of infectious diseases was erected, and Koch at that Congress in 1882 had once for all set forth the ætiology of phthisis.

Now a new enemy was at our gates, the plague, as the cholera was a hundred years ago. Now, we had succeeded in catching the individual sparks, might it be possible later to ward off the threatened outbreak. Influenza still threatened us, and the arm that the new century had welded for us was prophylaxis. With it we

should be prepared for tuberculosis, and that was our aim in the coming century.

The speaker then turned to the inquiries into the synthesis of albumen; through this should we learn to know how changes occurred in the organism, the situation of which we knew, but till now an insight into this had hitherto been hidden.

It was to be wished that a German science should be retained in the new century. The struggle against disease must remain International. In this the German government lead the van. March separately but stride unitedly to the conquering of disease.

Herr v. Koráing, Pesth, introduced a discussion on the

TREATMENT OF PNEUMONIA,

which has not yet been reported, but the discussion that followed the address indicates the trend of thought on the subject. Professor Pel, Amsterdam, was of opinion that simple observation at the bedside must mark out the part of rational treatment. In the first place the body must be guarded from the irritation proceeding from the infective germs and their toxins. The fever was possibly a true ally of the body. Unfortunately there was a series of cases in which the crisis did not come on, and which ran a slow course, as in the obese, renal and diabetic cases. It would be ideal if one could employ antiparasitic means, but at present there was none such. The search for the specific was universal, here was the disease, but where was the remedy? Our thoughts ran on articular rheumatism, malaria, and syphilis, but to render poison harmless, we wanted the antidote.

The chief representative of the remedial bodies was still quinine, then large doses of iron according to the recommendation of Niemeyer. The subcutaneous application of quinine was still on its trial. Italian inquirers had used potassic iodide for the reason that it had been used for everything. He rejected antiphlogistics, blood-letting, and all heroics that lowered the constitution. Digitalis was useful as a cardiac tonic, but taken as a whole we must say that there was no remedy by which we could shorten or influence croupous pneumonia. We were thrown back on to the curative power of the organism, that was to say, the less the physician interfered the better for the patient—as far as heroic remedies were concerned. To the physician remained, however, the glorious remedies, careful hygiene, nursing, and feeding. Symptomatic treatment of the cough, pain, &c., favoured natural recovery, as also did comfort and sympathy. Nothing should be too small, nothing too insignificant; it was a case of little things. None of the surroundings of the patient were without importance. A recognition of this marked the expert physician

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, April 28th, 1900.

IODIPIN.

FRIESER for some time past has been experimenting with iodipin, which seems from his results to have some rather peculiar and advantageous properties. In the first place, iodism is averted by the use of iodipin, while the effect of the drug and its action are more potent, although in the past this has been doubted.

Irritation of the stomach, which is also a prominent symptom in iodism, is quite unknown by the substitution of iodipin. The greatest peculiarity is that iodipin enters the system quicker than iodide of potassium or any other preparation of the drug, while it lingers in the system very much longer without injuriously interfering with any of the digestive functions. It does not seem to course in the blood circulation, but lies stored up in the fluid tissues of the body, where it is gradually utilised. It is strange, however, that iodipin passes through the stomach unaffected, and yet Frieser affirms that 15 minutes after administering iodipin by the mouth he found iodine in the saliva and urine, but none in the faeces; when injected into the rectum or subcutaneously it was longer in its appearance, in the former by four hours, in the latter several days. To show the time that it lingers in the cellular tissue, he gave a few instances of (1) a man who had acquired syphilis 28 years ago who was successfully treated with the drug, and 38 days after the last dose administered iodine was still present in the urine and saliva. (2) In another case it was present on the 43rd day. (3) In a third it was discovered on 46th day after the last dose. In all cases it was not to be found in the faeces. When iodipin was applied in the form of stipes, ointments, or paints, to the surface of the body none could be discovered in the secretions, although he is inclined to believe that a small quantity would be absorbed.

Frieser uses a 10 per cent. solution of Sesami oil and two to three teaspoonfuls in the day, or 15 to 200 grains as a "klysma." To cover the oily taste he prescribes it with oleo menthol, Cort. aurantiar, or Capilli veneris. A 20 to 25 per cent. is sometimes used, but this is too thick and syrupy, and must be warmed before application, even as a subcutaneous injection. The record of the curative effects is very satisfactory as to results.

ATAXIA.

At the "Medical Club" Erben exhibited a young man with prominent atactic symptoms in his movements. The knee phenomenon was present but not accentuated; there was no nystagmus. Tabes was excluded by the absence of the peculiar stamp, and multiple sclerosis from the absence of the spastic component, while the deep reflex was not exalted. In the history alcoholism, lues, and nicotine were also absent, although the father of our subject was a "Potator," and died of hepatic cirrhosis, but the mother was very healthy. At an earlier period the patient had fits, and when at school he had a severe fall from his unsteady gait, which last has increased within the last two years. Six months ago vertigo commenced with occasional headache, but no vomiting with it, although a difficulty in swallowing fluids was present. There was no disturbance in sensibility, the bladder, nor in the alimentary canal.

The nearest approach to an accurate diagnosis was Friedrich's disease, although others inclined to designate the condition as a morbid cerebellar process, owing to the persistent vertigo present, which is not consistent with ataxia. The protracted duration of the disease was against the idea of a cerebellar tubercle, however, is often very slow in its development. Syphilis was excluded from the absence of paralysis in the ocular muscles or of any symptom or previous treatment of that disease.

Schlesinger said he had had a similar case under treatment some time ago, and discovered that the father of

the patient had for many years suffered from a peculiar trembling; that the patient himself had formerly suffered from some disturbance in vision which had evidently been due to an atrophiea nervi optici. From these indications he concluded the disease was hereditary.

Rischawy asked Erben if he could give any explanation of the difficulty of swallowing fluids.

Teleky said that he remembered having a similar case which was even more chronic than this, and that after death a large carcinoma was found in the cerebellum.

Erben in his reply said that Schlesinger's diagnosis of heredity implied a form of agenesis in the cerebral substance extending to the medulla oblongata. No paralysis of any of the muscles in the region of the pharynx and larynx, neither atrophy nor fibrillary contractions were present anywhere to account for the difficulty in swallowing. The correct diagnosis he confessed was a matter of considerable difficulty.

TREATMENT WITH CARBONIC ACID GAS.

The treatment of morbid conditions with CO_2 is no novelty, as we have long admitted its potency in soda or potass water; more recently in baths, douches, lotions, &c., but we are now entering on a new application of the gas directly to the affected parts by means of compressed cylinders to which are attached tubes lined with nickel silver wire in contact with a battery for heating the gas. Muller showed a spray apparatus for applying CO_2 to the nose. When applied by Bernstein's instrument to the surface of the body it produced a mild form of irritation, was slightly rubefacient: 1st, the cutis anserina was followed by general reddening of the skin. It calms the pain of neuralgia, rheumatism and "ischias."

The Operating Theatres.

KING'S COLLEGE HOSPITAL.

OPERATION FOR CHRONIC APPENDICITIS.—Mr. CARLESS operated on a man, æt. about 30, by trade a slaughterer, who had for some time suffered from vague abdominal pains of a colicky nature which had been sufficiently severe to prevent him doing his work. These pains were mainly referable to the right iliac fossa, but spread in various directions, especially towards the right hypochondrium, so much so that during the last attack the possibility of its being due to some gall-bladder mischief forced itself upon the notice. Six months before the present admission he had been a patient under observation in the hospital for some weeks. His pain and other symptoms disappeared with the rest, and it was felt that there was not sufficient warrant for performing a laparotomy. After returning to his home in the country and to his ordinary work, however, the pain recurred, and if anything, with increased severity. He suffered at times with vomiting and the bowels were a little irregular. He was not particularly emaciated, there was no tenderness in the right iliac fossa, but something rounded could be felt to roll beneath the fingers; the abdomen elsewhere was normal to palpation. An incision was made, after the usual purification, parallel to the outer end of Poupart's ligament on the right side, and the peritoneum opened when the cæcum and ascending colon immediately pushed into view. It was at once obvious that the longitudinal muscular

fibres were more marked than usual, and the whole of the muscular walls of the bowel looked hypertrophied. On tracing the longitudinal muscular fibres the appendix was reached, and was found to be thickened and stiff, with its apex more or less fixed by a somewhat shortened and thickened mesentery. The appendix was freed from its mesentery as far as its base, and was then amputated in the usual way, a cuff of the serous and muscular coats being turned back and the mucous tube thus exposed ligatured with catgut, and divided, the sero-muscular cuff being also ligatured so as to cover in the former. The raw surface left by stripping the appendix off the cæcum was then covered over by suturing together adjacent portions of peritoneum. The abdominal walls were closed by deep silk sutures, which included everything except the skin and subcutaneous tissue, which were in turn secured by a continuous catgut stitch. Mr. Carless commented on the difficulty of diagnosis in this case: the symptoms were rather those of colic and irregular peristalsis than of any inflammatory lesion, and he had been quite ready to expect either a neoplasm or a stricture in the neighbourhood of the cæcum. He had also recently seen a case in which similar symptoms had been caused by a Meckel's diverticulum. Of course the most likely diagnosis was that of chronic appendicitis. It appeared as if, in the case he had just operated upon, the tip of the appendix was fixed to the peritoneum in the iliac fossa and thereby the free action of the gut was hindered, and excessive peristalsis of the cæcum and ascending colon was induced. In cases of this nature of persistent colic referable to the colon area, and not due to lead or other obvious causes there was always sufficient justification, in his opinion, for an exploratory operation. The appendix in this particular case was stiff and infiltrated, and the terminal three-quarters of an inch were solid and with its lumen quite occluded.

CHELSEA HOSPITAL FOR WOMEN.

HYSTERECTOMY AND REMOVAL OF A LARGE RETRO-PERITONEAL FIBROID.—Dr. EDEN operated on a single woman, æt. 39, who had been admitted complaining of abdominal pain and swelling noticed some few months. The menstrual period had been regular and moderate in amount, and she had no further complaint. On examination a large abdominal swelling was found, external to and two fingers breadths above the umbilicus. Owing to the rigidity of the abdominal walls, examination was rather difficult, but the growth was thought to be solid, and probably a fibroid. On vaginal examination the cervix was found displaced to the left side of the pelvis. She was admitted to the hospital with a diagnosis of large subperitoneal fibroid, absence of bleeding seeming to indicate that the growth was not interstitial. After repeated examinations this view was modified. The growth felt so soft on palpation that, although fluctuation was never definitely detected, it was thought that it was probably cystic; more careful vaginal examination revealed the fact that the uterus was lying at the left margin of the tumour, and was carried well above the pelvic brim appearing to be quite distinct from the growth. It was, therefore, thought probable that the case was one of cystic tumour, occupying the broad ligament. At the operation, on opening the abdomen it was at once clear that the growth was under the peritoneum. The parietal peri-

toneum was reflected from the anterior abdominal wall on to the surface of the tumour a little to the right of the middle line, the line of reflection coming well into view when the edges of the incision were retracted. On the left the peritoneum passed directly over on to the uterus, the pouch of Douglas was very shallow, reaching only a little below the level of the sacral promontory. To touch, the growth felt very soft and yielding, and was still thought to be cystic. An attempt was therefore made to tap it with a large trocar, but the instrument would not enter. A smaller trocar was then tried with a similar result. It was now clear that the tumour was a soft solid, the peritoneum covering it was therefore incised for about three inches, a line of cleavage easily found, and the whole growth enucleated without serious difficulty. There was a little trouble in detaching it from the border of the uterus, but there was no true pedicle at this or at any other part. Owing to free bleeding from the bare uterine surface the uterus was next removed in the usual way by ligation of vessels and amputation at the level of the internal os. The right tube and ovary were removed along with a considerable portion of the loosed sac; the left appendages were saved. The peritoneal sac left by enucleation gave little trouble, two or three points required ligature, but there was no general oozing. The walls of the sac were now brought together with a series of mattress sutures, and the peritoneal edges finally united by continuous sutures right across the pelvic floor covering in the stump of the cervix. Dr. Eden said the case illustrated a very common difficulty in diagnosis, *i.e.*, the distinction between a soft solid and a cystic growth. No single sign, he remarked, could be depended on in distinguishing these two, and until the abdominal cavity is opened diagnosis must always be practically guess-work. The absence of menstrual or other hæmorrhage was, he thought, no doubt explained by the fact that there were no fibroid growths in the uterus itself. The uterus in this case, he said, was removed on account of the free oozing, otherwise the proper course would have been to have saved the organ. He pointed out that the advantage of leaving at least one ovary in cases of hysterectomy is now well recognised, the resulting artificial menopause being much less severe than when both are removed.

It is interesting to note that on the first day after operation the patient's condition was satisfactory in every respect. On the second day the pulse averaged 110, and on deep palpation a soft swelling could be detected in the right iliac region. No doubt some effusion had occurred into the peritoneal sac. On the third day the pulse was 84. Her progress towards convalescence was subsequently uninterrupted.

The Mortality of Foreign Cities.

THE following are the latest official returns, and represent the last weekly death-rate per 1,000 of several of the populations:—Calcutta 65, Bombay 166, Madras 37, Paris 22, Brussels 19, Amsterdam 15, Rotterdam 21, The Hague 18, Copenhagen 17, Stockholm 17, Christiania 21, St. Petersburg 30, Moscow 29, Berlin 20, Hamburg 15, Dresden 21, Breslau 24, Munich 27, Vienna 27, Prague 28, Buda-Pesth 29, Trieste 37, Rome 21, Venice 22, Cairo 36, Alexandria 27, N. w York (including Brooklyn) 23, Philadelphia 26.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, MAY 2, 1900.

HOUSE-INFECTION IN ENTERIC FEVER.

FOR various reasons the spread of enteric fever by house-infection has hitherto escaped the attention it deserves at the hands of practical sanitarians. The tracing of outbreaks of the disease to the agency of infected milk or water has furnished so many brilliant pages in the history of preventive medicine that there has resulted a natural tendency to overlook the comparatively prosaic process of infection through the domestic environment. In the houses of the poor, however, where whole families are not unfrequently huddled together in close contact, this personal factor becomes one of great importance. This aspect of the disease was ably dealt with at the Plymouth meeting of the British Medical Association by Dr. Peck, of Chesterfield, who gave the history of an outbreak, in which a large number of cases could, in all probability, be attributed to house infection. This proposition, indeed, becomes reasonable enough when the facts of the case are taken into consideration. The patient as a rule suffers from diarrhoea, and the discharges therefore, charged with pathogenic bacteria, cannot fail to contaminate clothes, bedding, utensils, and other immediate surroundings. The only wonder is that under such circumstances any person living in one of the overcrowded houses of the poor can escape the disease. The explanation of such partial incidence may probably be found in the difficulty of aerial distribution of the specific germs, and it seems not unlikely that the majority of cases that actually occur are due to indirect transference of the virus by non-aerial means. Anyway, the danger exists, and is increased in direct ratio with the amount of overcrowding in the invaded house. The difficulty of treating a poor typhoid fever

patient at home with any degree of safety to himself and to others is simply insurmountable. The need of adequate special hospital accommodation for enteric fever in every large sanitary district is therefore evident, and the poorer the population the greater is that need. It is somewhat surprising to learn that Birmingham is not provided with such an institution. The cases of typhoid fever in that city numbered one hundred more than those reported in any previous twelve months, and reached the total of 637 with 113 deaths, as against 260 cases with 39 deaths in 1892. This marked increase of 1898 has been reported upon by Dr. Hill, the well-known Medical Officer of Health, for Birmingham. From an analysis of the cases he arrived at the conclusion that at a low computation at least 86 were due to secondary house-infection. In other words, if removal to hospital had taken place promptly, probably most, if not all of these 86 cases, amounting to one-seventh of the total number, would not have occurred. He made the further important observation that in 106 cases where the first patient was removed to hospital there was only one instance of secondary infection, whereas in 199 primary attacks treated at home there were no less than 19 secondary invasions. On these and other grounds Dr. Hill has founded a strong plea for the necessity of special typhoid fever hospital accommodation, and it is not easy to see how that responsibility can be avoided by a progressive and responsible body such as the Health Committee of Birmingham. The evidence in favour of removing all cases of enteric fever occurring in small houses is simply overwhelming. Not only would such a step add considerably to the safety of the patient and lessen the chance of involving other inmates of the infected house, but would also do away with the spread of infection in adjoining houses. The system at present in vogue in Birmingham of removal to a general hospital or a Poor-law infirmary is of great value although seriously limited by the tardiness with which such removals take place. Prompt hospital isolation means, to quote the words of Dr. Hill, "an advantage to the patient, whose chances of recovery would be greatly increased; it would be an advantage to other members of the household, who would run much less risk of being infected; and an advantage to the general public, to whom the disease frequently becomes communicated when proper isolation and disinfection are not carried out." The question thus raised is one of vital interest to the community at large. Enteric fever is essentially a preventable disease, and before the advance of modern sanitation it has decreased in a most encouraging manner. There is no reason, however, why this terrible disorder should not be rooted out of any community, or portion of a community, in which public health and ministration is carried out in accordance with acknowledged principles. The occurrence of a case of typhoid fever in a well-ordered district is the signal for rigorous inquiry and stringent measures of prevention. In the ideal administrative area there would of course be ample

special fever accommodation, so that the question of any serious spread of the invasion by house infection would not arise. Indeed, so well recognised are all these facts that their repetition becomes mere platitude, and it is hard to realise that any wealthy corporate community in this year of grace should lack an isolation hospital for the reception of cases of enteric fever.

HOSPITALS AND FRIENDLY SOCIETIES.

A VERY mistaken idea of the objects with which hospitals are founded appears to prevail among various sections of the public. The primary stipulation that they are intended for the reception and treatment of the indigent poor seems to be overlooked with the result that subscribers and others claim, and often, indeed, virtually exercise the right to obtain admission for persons in whom they are interested without regard to their social or medical eligibility. In illustration of what we mean we note that at the recent meeting of the Cardiff and District Friendly Societies Council the Chairman sharply criticised the administration of the Cardiff Infirmary apparently on the ground that unless a member happened to be seriously injured he was not kept in but was referred to his club doctor. He added that they would subscribe much more liberally to the institution "if it were conducted on the lines which it ought to be," that is to say, no doubt, on lines to be laid down by the friendly societies. The speaker complained, moreover, that there was "too much doctor" about the institution, surely a rather strange indictment. A hospital without a doctor would be less complete than the proverbial home without a mother; *ergo* is it possible to have too much doctor in a medical institution? These critics are really too difficult to please! Their stereotyped reproach is that there is not doctor enough, and now we are told that they have too much of what they would hardly deny is a good thing. We get an inkling of what they desire in a remark which fell from another speaker, who plaintively contrasted the management of the Cardiff Infirmary with similar institutions at Bristol, where, he asserted, patients "were not asked what they earned." Is it seriously contended by these grumblers that hospitals should be thrown open to any and every sick person with or without a letter of recommendation? The poor would be the first to suffer, because the better classes of society, having more influence, would infallibly obtain precedence, and no room would be left for their less fortunate brethren deserving of assistance. What these gentlemen have in view apparently is a sort of club-hospital to which an annual subscription would confer the right of admission. Such a suggestion has much to recommend it, but before it could be got into working order several difficulties would have to be surmounted. First of all, even if the wage-earning limit were abolished, it would be necessary to lay down what we may call a medical limitation, otherwise the beds would be filled by persons suffering from comparatively trivial or chronic ailments

to the exclusion of the, medically-speaking, deserving cases. Then again if the hospital is to be run on commercial or friendly society lines, some provision would have to be made for remunerating the Medical Officers, who would certainly object to become the unpaid servants of a sort of assurance company against sickness. Gratuity of service is conditional on such service being restricted to certain categories of patients, and even as matters stand at present we are within measurable distance of the time when, in view of the altogether unfair amount of work thrown on the medical staff of hospitals by reason of the abuse of the out-patient department, pressure will be brought to bear on consultants either to insist on a measure of reform or to require adequate remuneration. It is well that these considerations should be brought to the notice of those whom they may concern especially in view of the prospect opened up by the chairman of the Friendly Societies Council, who confidently stated that "there are going to be ructions" on the committee appointed to discuss the reconstruction of the infirmary management.

THE GENERAL MEDICAL COUNCIL AND THE ENGLISH CONJOINT BOARD.

THE Royal Colleges in London are having an anxious time just now as they have to decide definitely upon the course which they will pursue at the forthcoming meeting of the General Medical Council in regard to the Council's resolutions requiring them to recognise as institutions for the teaching of science to medical students only such as have been approved by the Council. Should the Colleges maintain their present recalcitrant attitude in the face of the almost unanimous feeling of the Council two courses are open to the latter body who may decline to the register diplomas granted on conditions at variance with the recommendations, leaving it to the diplomates or the Colleges to obtain a judicial decision on the points at issue. The other alternative would be for the Council to withdraw the concession whereby medical students are authorised to receive instruction in these branches elsewhere than at medical schools. This, however, would be unjust to the other licensing bodies which, for the most part, have complied with the spirit as well as the letter of the Council's regulations. We are not concerned with arguments bearing on the desirability, or otherwise, of the Council's undertaking the regulation of these branches of study, and we are not sufficiently versed in legal matters to feel justified in expressing an opinion as to the construction to be placed on the terms of the statute, in virtue whereof the Council admits to and controls the education of medical students. Inasmuch, however, as chemistry, biology, and physics actually form part of the curriculum over which the Council has uncontested controlling powers, common sense would lead one to infer that the Council's claim to interfere was well founded. Lastly, except from the point of view of *amour propre*, it is difficult to understand what

useful object the managers of the Conjoint Board hope to attain by setting this example of insubordination in high places. It has been suggested that the presidents of the Colleges should meet the president of the Council and talk the matter over, but the idea was negatived, and we must admit that an interview would probably have led to no practical result, seeing that these gentlemen have already had ample opportunities of discussing the subject unofficially, had they desired to do so. Matters will be brought to a head at the ensuing session, and it is perhaps as well that this conflict of jurisdiction should no longer be permitted to vex the attention of the profession. Its importance is out of all proportion to the actual scope of the question at issue, for it is essential that the paramountcy of the Council in all that appertains to medical education should be established and acted upon.

Notes on Current Topics.

The War as a Determinant of Sex.

The precise point marked by the parting of the paths of development in the ovum that determines the sex of the embryo has always been a matter of scientific curiosity. Up to the present time the matter has been wrapped in the dim temple of speculation, from which no seer, however gifted, has been enabled to lift the veil. Indeed, the spectacle is yet vivid in the memories of the world of the famous Austrian professor, who has been deprived of his professorial status because of the publication of an unsubstantiated theory as to the predetermination of sex in the embryo. With this recent example in view it is somewhat surprising that any medical man should be courageous enough to publish to the outside world anything bearing upon the subject. The Medical Officer of the Normanton Urban District Council, however, has not been deterred from that course, if we may accept the report of what the *Leeds Mercury* calls an "extraordinary statement." In his annual report he wrote:—"There is a difference in the sex birth-rate, the male births being 240, against the females 218, and whether the excitement of patriotic feeling anticipating the war had anything to do with this unusual determination of sex I cannot say; but considering the intense desire recently shown by some of the population to get to the front, I think it quite possible that such feeling may have had some influence." The reading of this passage was received with "loud laughter" by the Council, who may be congratulated upon their sense of humour. The figures are far too small to furnish any sound conclusions, and the disproportion is equalled in many parts of the United Kingdom. The Medical Officer, however, has committed a more serious fallacy. His report covers the year 1899, during the last three or four months of which war was going on. Does he assume that the maternal interest in martial affairs was so overwhelming as to change the sex of the fetus in the last two or

three months of pregnancy? Otherwise it is not easy to see how the theory is to be applied. To fill a report is not always an easy matter; but absurdities of this kind, while they may tickle the ears of lay committees, will do nothing to advance the position of the medical officer of health as an instructor of the community.

Æsculapius and His Temple

THE early history of the medical art centres more or less round Æsculapius and his shrine, and some very highly interesting details concerning his great temple at Epidaurus are given in a paper which Dr. W. S. Colman read not long since before the Medical and Physical Society of St. Thomas's Hospital, and which has since been published in Vol. XXVII. of the *Hospital Reports*. Dr. Colman gives us a vivid picture of the strange combination of religion, medicine, and downright charlatanism which characterised the "cures" at this once famous spot. Just as many centuries later Rabelais found it necessary to disguise his political disquisitions in literary garments of strange, even repulsive, make, so the followers of Æsculapius found it answer to avail themselves of the superstitious proclivities of the sufferers for the purpose of inducing them to place themselves under conditions favourable to recovery. That the priests did not trade exclusively on superstition and ignorance may be inferred from the ample provision made for baths, gymnastics and orthopædic exercises. The treatment, or shall we say service, seems indeed to have been a blend of the open-air treatment of consumption with a trace of the modern massage establishment (testified to by the existence of a temple devoted to Aphrodite in the immediate neighbourhood), a course of calisthenics *à la mode* Sandow, with the hydro-pathic and pine treatments thrown in. In those times acute diseases were presumably left to take care of themselves, and preventive medicine, except of the incantation kind, was unknown. They were not yet known to be preventible, so that the question why they were not prevented could not arise. Formerly the grateful patient accorded the credit of his recovery to the particular deity invoked by him and formally recorded the fact in a votive tablet at the shrine or temple. Nowadays the physician or surgeon claims, and is awarded, the credit, if credit there be, and the "votive tablet" is presented to a medical society or printed in a medical journal for the edification of those who suffer, and as an invitation to them to go and do likewise.

A Herbalist's Cough Mixture.

A RECENT inquest at Stamford reveals the extraordinary attitude of the average jurymen with regard to unqualified medical practice. The inquiry was held upon the death of a child twelve months old. The mother deposed that she gave the child medicine purchased of one Day, a herbalist. A medical man certified that death was due to bronchitis and convulsions, and might have been averted under proper medical advice. The cough mixture given by the

herbalist contained paregoric, which would check expectoration in bronchitis, and was therefore unsuitable. It also rendered the convulsions more serious. The foreman of the jury was ruled out of court when he desired to summon the herbalist, so that they might direct him in future to affix more precise directions upon his labels. To the verdict of death from natural causes was added a rider that the herbalist Day was guilty of negligence in not giving proper directions for administering his mixture. This rider abundantly illustrates the absurd state of the law with regard to unqualified medical practice. Here in the full light of day it is proved in an English legal court that an unqualified man has physicked an unfortunate infant to death. The only notice taken by the jury of his illegal action is to advise him to be more careful of his labels. A coroner, rightly or wrongly, is not usually accredited with a deep knowledge of the law, but how such a ludicrous travesty of judicial process could escape him in the present instance is past the average understanding. Can our Medical Defence Societies do nothing in a case of this kind?

The Transfusion of Complete Blood.

AN American physician, Dr. Davis Hard, has been experimenting upon himself in regard to the possibility of transfusing "complete" blood. In one experiment he took four ounces of blood from a vigorous yearling goat and injected it into his median basilic vein. As the result of this he noticed subjectively a peculiar mental acuity and facility of thought, accompanied by undue exuberance of spirits of an optimistic nature, and among other things he developed an excessive appetite. Insomnia, however, followed for three days after the transfusion, and he experienced slight cephalic fulness and tinnitus aurium for about a week. Having allowed two weeks to elapse he caused four ounces of blood to be taken from a healthy young male and injected into his venous system. In this instance the subjective symptoms were about the same as on the former occasion, but if anything not quite so marked, while both albumen and sugar in small amounts were found in the urine, and urea was in excess. In addition there was a notable increase in the number of red blood cells. After Dr. Hard has experimented upon himself, his assistant, Mr. Wyman, was inspired to do likewise, with the result that after eight transfusions with male blood, at the end of 30 days, there was an increase of 8 per cent. in the assistant's red blood corpuscles, 12 per cent. in white cells, 6 per cent. in body weight, and "a general exaltation of all bodily functions."

THE plague continues to claim victims in Sydney, and plague-infected rats have been found on the Brisbane, Auckland, and Melbourne wharves

At the meeting of the Royal Medical and Chirurgical Society on Tuesday next (May 8th), Mr. Frederick Treves will deliver an address on military surgery. He is likely to receive an ovation.

Analysts Analysed.

VINEGAR is assumed for purposes of analysis to consist of dilute acetic acid, and the discovery of any foreign acid of appreciable proportion is, or has been, accepted as evidence of adulteration. A well-known firm of vinegar manufacturers have just succeeded in satisfying a magistrate that the presence of combined sulphuric acid within certain limits ought not to be regarded as proof that the product is other than "of the nature, quality, and substance demanded." Their contention was that the addition of a certain proportion of sulphate of lime to the water is necessary to the manufacture of vinegar on commercial lines. Moreover, a further objection was taken to the analyst's statement that sulphuric acid had been added, whereas the acid existed in the form of gypsum, a neutral body, it being pointed out that a substance in chemical combination with another is not the sum of its constituents, but something quite new. We must leave to experts to decide whether or not this defence should be allowed to stand, but we cannot refrain from expressing disapproval of the loose system of making analyses in which the analyst contents himself with estimating the "total acids" without taking the trouble to ascertain the source thereof, and the form in which they are present.

The Midwives Question in New York.

A LAW has just been passed by the State Legislature by which all midwives desirous of practising in New York City are required to pass an examination before a commission of five medical men appointed by the Board of Health. Presumably, after passing this examination, the women are provided with certificates enabling them to practise. This arrangement does not seem to differ from that carried out by the Obstetrical Society, except in the fact that in New York the examination is compulsory. It would be of interest to learn if this regulation meets with the approval of the medical profession. New York, as is well known, is a great centre, by means of the dispensary system, for wholesale gratuitous medical advice and treatment, and it is just possible that the launching of a large number of certificated midwives upon the public may still further reduce the attenuated emoluments which are still accessible to members of the profession.

American Medical Societies.

THE United States is certainly the "happy hunting ground" of medical societies. In a list published by the *Journal* of the American Medical Association the names appear of upwards of 700 various medical societies which are entitled to be represented at the annual meeting of the Association to be held in Atlantic City on June 5th and following days. But even this number is probably far from complete, for not all of the existing societies have the right to send a delegate to the Association. The mass of literature added to the burden already thrown upon medical men in the course of the year, assuming that the proceedings of the same are regularly published, must be enormous. In the absence of some means

of winnowing, condensing, and generalising all this wisdom, the experience runs largely to waste, and it is difficult to suggest a practical scheme by which this intellectual waste can be averted.

The Vacant Parliamentary Representation of Edinburgh and St. Andrews Universities.

MR. J. M. BARRIE, the well-known author and play-wright, has been invited to oppose Sir John Batty Tuke at this bye-election. At the time of writing it is uncertain if Mr. Barrie will consent to be nominated, while report has it that he does not regard the proposal very favourably. The nomination day is to-day (Wednesday), so that if he refuses the chances of a contested election are very small. Mr. Barrie is an old student, we believe, of the University of Edinburgh. Were he to be elected it will be of much interest to see how the originator of "Thruwa," the successful author of "The Little Minister," and one of the pioneers of the "Kail-yard" School acquits himself within the walls of that most levelling of institutions, the House of Commons. Sir Batty Tuke is, as most of our readers know, one of the most distinguished psychologists in Europe and a noteworthy scientist as well, and he has taken a very prominent position as a member of the General Medical Council. His father and his grandfather were philanthropists of the most active type, and were largely, with the assistance of William Wilberforce, influential in bringing to an end the atrocities perpetrated on poor lunatics in the times of our grandfathers. Unfortunately, in these University elections, the academic merits of the competitors are, to a great extent, merged in their political opinions, for which reason Mr. Barrie will, no doubt, receive a strong support for his party.

The Influenza Epidemic in Scotland.

ALTHOUGH influenza in active epidemic form has now ceased to attack the people of Scotland, perhaps after none of the epidemics of recent years have the annoying and depressing after-effects been so noticeable. It is to be hoped that after the Easter holidays, which are now at a close, the general condition of the victims will prove more satisfactory; before then it might have been said that most members of the middle and richer classes needed a thorough spring cleaning. It is also a fact of importance to note that a large number of post-influenza patients presented few symptoms of the active disease previously, or even nothing more than those of a slight common cold, to be followed by all the protean manifestations attendant on influenzal toxins.

Non-Immunity from Glanders.

UNLIKE most infective diseases of bacterial origin glanders has been shown not to confer immunity against a subsequent attack in the dog and Professor Nocard, the well-known French veterinary authority, has satisfied himself that the same observation holds good in respect of the horse.

Sea-Side Resorts Off Season.

It is not a little curious to note how the inhabitants of Great Britain and Ireland, in spite of their insular prejudices, are wont to underrate the value of their own spas and watering places. During a few months in the summer a number of fashionable seaside resorts are crowded to excess, accommodation runs up to famine prices, until with the first breath of winter a sudden and complete exodus begins. Then comes the opportunity for those who are merely in search of health, and who do not mind dulness of surrounding. For such folk there is an almost boundless selection of apartments with board and lodging at the lowest possible price. Indeed, for many families of moderate means who are not obliged to live in the neighbourhood of large towns it would be difficult to imagine a more economical place of residence than a fashionable seaside resort out of season. For a tired literary man the quiet, the healthfulness, the absence of distraction, and the small cost of living under conditions of the kind would render it an ideal locality. For the invalid of any class or station, rich or poor, sick or convalescent, what could be better or more desirable? Clearly, many of our citizens would do well to look round at home before they fly to continental health refuges, where expenses, run high and where sanitation is often in its infancy. By so doing, moreover, they would be benefiting their fellow-countrymen, for the straits to which the lodging-house keeper at the seaside is often put in the off season are nothing short of heart-rending. Let charity begin at home is an excellent maxim, worthy above all of application to the holiday resorts of the United Kingdom.

Motor Car Pathology.

EVERY new fashion brings its own peculiar mischief to mankind, at least, so say the philosophers. That being the case it is of some interest to speculate as to what particular evils are likely to follow in the track of the motor car, a method of locomotion that will undoubtedly take a front place in the not-distant future. The bad results of constant railway travelling have been graphically portrayed by various nerve specialists, and are usually regarded as falling upon the nervous system. At the same time it may pretty safely be assumed, *pace* the specialists, that the average healthy man is not damaged to any serious extent even by an extreme amount of travelling in railway carriages. Those likely to suffer are persons with a tendency, inherited or acquired, to neurotic affections. If we may ascribe "railway" nerves to the constant succession of jolts and jars incidental to that form of transit, it seems clear enough that a similar effect will ensue from riding on the average automobile car. In the present stage of development, at any rate, locomotion under such circumstances appears to be a sustained concatenation of bumping, thrills and intermittent thumps, accompanied by a continuous and unobtrusive undercurrent of noise. Apart from

possible nervous strain the most obvious mischief will apparently be to the eyes, arising from long exposure to wind and dust. Indeed, many motor riders have adopted sun and dust goggles as a matter of routine. The noise and the jolting of the cars will no doubt be minimised by better construction; but it is not easy to see how the effects of sun and wind can be altogether excluded.

The Fellowship of the Royal Society.

IN pursuance of the statutes at the March meeting of the Royal Society, Lord Lister in the chair, the names of candidates for election into the Society were read, and the list was a lengthy one, so far as members of the profession are concerned. Among those aspiring for the honour of the Blue Riband of Science, are Major Alcock, I.M.S., Mr. C. A. Ballance, Dr. Mitchell Bruce, Dr. Sydney M. Copeman, Professor Edgar Crookshank, Professor David I. Hamilton, Dr. Leonard Hill, Dr. Patrick Manson, Dr. C. J. Martin, Dr. Joseph Payne, Dr. Risien Russell, Dr. James L. Smith, Dr. William R. Smith, Dr. Johnson Symington, Dr. Hale White and Dr. Sims Woodhead. Altogether the candidates for election are 86 in number, and inasmuch as only 15 new Fellows are elected annually, it follows that there will be a good many disappointments when the election takes place.

The Surgeoncy of the Meath Hospital, Dublin.

THE vacancy in the staff of this hospital created by the recent death of Dr. Glasgow Patteson was filled last week by the appointment of Dr. Edward Taylor. He holds the M.D. (Stip. Cond.) and the B.Ch. of the University of Dublin, granted to him in the year 1896, and he has enjoyed the distinction of having won from the University the surgical travelling prize, and also a medical scholarship. He furthermore obtained the Fellowship of the College of Surgeons in 1896. In the hospital to which he has now been appointed as surgeon he served as house surgeon and resident pupil, and in the school of the College of Surgeons took the gold medal in operative surgery and the Mayne scholarship in 1893.

The Anti-Tuberculosis Congress.

THE International Anti-Tuberculosis Congress attended by more than 1,000 delegates from all parts of the world, was opened in the San Carlo Theatre, Naples, on the 25th ult., in the presence of King Humbert, Queen Margherita, the Prince and Princess of Naples, and the Duke of Genoa. Among the foreign delegates present were the Duke of Ratibor and Professor Virchow, from Germany, and Dr. Lannelongue, from France. The first sitting of the Congress was devoted to a discussion of the prophylaxis of tuberculosis.

NEW JERSEY, in America, will be the scene of the annual meeting of the American Medical Association, which will take place from June 5th to 8th next.

The Reception at the Reform Club.

THE return of Sir William McCormac and Mr. Frederick Treves from the front was the occasion, on Saturday evening last, of a congratulatory dinner offered to these distinguished surgeons by the members of the Reform Club, or some of them, and special *éclat* was conferred on the proceedings by the presence of that genial ex-political philosopher, Lord Rosebery, in the capacity of chairman. In the remarks with which the chairman introduced the toast of the evening a happy note was struck when he observed that amid all the criticism and fault-finding concerning the war no dissentient note had been heard in respect of the excellent management and conduct of the medical service. The public having been unanimous in praising the "cold, deliberate, thoughtful and conscientious patriotism" of the medical staff whose claim to grateful recognition have been recently emphasised in the person of Major Baptie, V.C., Sir William McCormac and Mr. Treves replied, and the latter, in an amusing sally, declared that the two plagues in South Africa at the present time were flies and women. Many of the latter, he observed, having exhausted other forms of excitement, had "gone in" for nursing and adjourned to the scene of the war, where they masqueraded in summer dresses and arranged picnics. Evidently Mr. Treves is a misogynist. Let him beware!

The following comprise nearly all the medical men who are members of the club, and were present at the banquet:—Mr. Buckstone Browne, Mr. Mayo Collier, Dr. Farquharson, M.P., Dr. Habershon, Dr. Hastings, Dr. Jessop, Dr. Stephen Mackenzie, Dr. Mapother, Mr. Malcolm Morris, Sir C. Nixon, Dr. Ogilvie, Dr. S. Townsend.

A Statue to Huxley.

WITH a proper sense of the fitness of things a statue of the late Professor Huxley, that essentially amiable but combative philosopher, has been placed in the Natural History Museum at South Kensington as a pendant to that of his reverend master, Mr. Darwin. The statue, which has been erected by subscriptions received from all parts of the world, was formally installed on Saturday last with a brilliant ceremony, which afforded Huxley's admirers and followers an opportunity of proving that his memory is still green in their hearts. The Prince of Wales was present, and on the statue being presented to him as one of the trustees of the British Museum by Sir Joseph Hooker, his Royal Highness expressed the satisfaction he felt at being privileged to take over this statue after having performed a similar service to the memory of Charles Darwin. The Duke of Devonshire and Sir Michael Foster also spoke, the latter insisting particularly on the amiableness of character which had characterised Huxley, whose combativeness was directed to furthering the cause of open unprejudiced inquiry rather than with the object of imposing the acceptance of Darwin's views.

Amateur Legislation.

THE Infant Life Protection Act, from which so much was anticipated when it was under discussion last year, appears to be a sorry piece of legislation, presenting many points of resemblance with the *ridiculus mus*. An attempt to put one of its clauses in force against a woman who had set the spirit, if not the letter, of the law at defiance in regard to the rearing of foster children, broke down completely when brought before the magistrate at the West London Police Court on Saturday last. The only penalty provided in the Act apparently is the forfeiture of the money handed over with the second child, but even so there are no means of enforcing payment except by ordinary civil process. With so many lawyers in Parliament it is little short of a disgrace that such slipshod legislation should have been allowed to become law. An amendment of the Act becomes urgent in the interest of the infants whom it is intended to protect, and last, but not least, to wipe out all trace of this discreditable carelessness.

The Riberi Prize.

THE valuable prize of £800 is to be awarded by the Royal Academy of Medicine at Turin on the last day of the present year for the best discourse or literary work on experimental pathology, hygiene and forensic medicine which has been made known within the past five years.

ALL men belonging to the German army medical service are required by a recent regulation to acquire the ability to ride a bicycle. The use of this convenient means of progression has been permitted for some time past to army surgeons' assistants. Although South Africa is not on the whole an ideal cycling country, we hear now and again of the cycle having been requisitioned for the conveyance of despatches. It will be time enough for the R.A.M.C. to take to the cycle when cycling corps have become an integral part of the line.

MAGISTRATES in various parts of the country seem to take a malicious delight in discovering absurd reasons for stultifying proceedings against vaccination defaulters. A few days since a batch of summonses were dismissed because the signature of the vaccination officer was stamped instead of being written, and more recently the bench at Frome dismissed some summonses because the officer had signed his name in the wrong place, though we doubt very much whether the law defines any particular place for the signature.

THE extra expense which the Vaccination Law has thrown upon certain local authorities in consequence of the arrears which have to be made up has rendered some of them dissatisfied, and an endeavour has been made in several instances to reduce the fees in consequence. As might be anticipated, the Local Government Board has declined to acquiesce in the suggestion, and quite recently addressed communications to the Bury Board of Guardians to that effect.

THE National Deposit Friendly Society, in sending us a copy of their thirty-first annual report, call our attention to the fact that the medical pay for members averaged 2s. 5½d., equal to one shilling per each day's sickness experience, the average sickness of the Society being 2·57 days per member. It is pointed out that if the ordinary friendly societies paid at the same rate for medical attendance their annual payment per member would be 10s. instead of 4s.

PERSONAL.

MAJOR M. W. KERIN, Lieutenant Martin, and Lieutenant Sloan, R.A.M.C., have left South Africa for England.

PROFESSOR CLIFFORD ALLBUTT has been unanimously elected an honorary physician to Addenbrooke's Hospital, Cambridge.

DR. CHARLES MCBARNEY, has resigned the post of Surgeon-in-Chief to the Roosevelt Hospital, which he has held since 1888.

SIR JAMES WESTLAND, K.C.S.I., LL.D., will take the chair at the annual meeting and dinner, on the 17th inst., of the Aberdeen University Club.

DR. JOHN JONES, of Clydach, Swansea, having been appointed civil surgeon to Her Majesty's forces in South Africa, has been presented with a purse containing £50 by his townsmen prior to his leaving for the front.

MR. W. H. LLOYD, M.R.C.S., Medical Officer of Health for the Llandilo rural and urban districts, and Surgeon-Captain of the 1st Volunteer Battalion, Welsh Regiment, has been presented with a brcugham and a purse containing £120 as a mark of esteem on the occasion of his silver wedding.

THE costs in the recent action which Mr. E. W. Jollye, M.R.C.S., of Domington, Lincoln, was compelled to defend, and which was dismissed, have been covered by the presentation of a cheque for £200 and a silver salver by sympathising friends and neighbours.

SIR WILLIAM MCCORMAC, accompanied by Captain Symon, R.A.M.C., has returned to this country, and the opportunity has been greedily turned to account by the interviewers, who succeeded in eliciting a certain amount of interesting information bearing on his recent experience.

THE election of Examiners for the coming year took place as required by the charters of the Royal College of Surgeons, Ireland, on the first Tuesday in May, i.e., yesterday. The hour at which the election was completed precludes our giving the names of the successful competitors in our present issue.

SIR FRANCIS HENRY LOVELL, C.M.G., Surgeon-General of the Colony of Trinidad and Tobago, has been presented with an illuminated address on the occasion of his knighthood, a distinction which is stated to be without a precedent in the history of the colonial medical service, titular distinctions having been hitherto conferred only on or after retirement.

MR. FREDERICK TREVES, late of South Africa, contemplates, according to a provincial contemporary, early retirement from active practice, with the intention, we are assured, of seeking a well-earned repose in Parliament. We welcome every medical recruit to the legislature, which is singularly poor in representatives of the medical profession, being in this respect a striking contrast to every other legislature in the world.

By the recent death of Mrs. Cogan, widow of the late Right Hon. W. Cogan, Dr. Thomas More Madden succeeds to the estate of Tinode, in the county of Wicklow, he being a nephew of the deceased gentleman. Mr. Cogan was a Privy Councillor for Ireland, and represented his county in Parliament for many years. Dr. Madden is son of the distinguished antiquarian *litterateur*, Dr. More Madden, and he himself has occupied a prominent position in the profession in Ireland as an obstetrician, and as Physician to the Mater Misericordiae, Hospital, Dublin. His contributions to the literature of the profession, both in our own tongue and in foreign languages have been numerous, many of them having appeared in THE MEDICAL PRESS AND CIRCULAR.

Literature.

PAGET'S ESSAYS FOR STUDENTS. (a)

THESE essays were written for students only, but are so full of practical hints derived from large experience in daily surgical work that they appeal quite as forcibly to graduates of every description. Their great merit lies in the fact that they are based upon actual cases, their personal and individual characteristics, exactly as one would encounter them in private or in an out-patient department of a hospital; the symptoms being emphasized and discussed as to their significance and gravity, more fully than the pathological physical signs, although these are by no means discarded altogether. The fault of most surgical, and alas, of medical text-books, lies in the disproportionate importance ascribed to what is wrong, its anatomical features and pathological condition, compared with the accounts of the symptoms, present and antecedent, and modified by personal or physical attributes, as they present themselves to the practitioner in the course of his daily work. Text-books are generally conceived in hospital wards; born in the midst of leisurely professional luxury; grown under little stress. Mr. Paget's essays will serve as a corrective. They place before the reader the various important facts as met with in actual practice in cases of strangulated hernia, cancer of the mammae, "run-over" accidents, and ear diseases. The essay upon strangulated hernia, and the chapter upon the elements of auricular surgery deserve to be read by every medical man, student, practitioner, surgeon, or consultant.

PICKERING PICK'S SURGERY. (b)

THIS handsome volume contains the substance of the lectures on surgery which Mr. Pickering Pick has "delivered at St. George's Hospital for fifteen years—modified, of course, from time to time in accordance with the advances made in the science and art of surgery." The author informs us that "the book has been written mainly for students, but I hope that practitioners will find it a useful work

(a) "Essays for Students: 1. Strangulated Hernia; 2. Cancer of the Breast; 3. Run-over Cases; 4. Auricular Surgery. By Stephen Paget, F.R.C.S. One Vol., price 3s. 6d. London: Baillière, Tindall, and Cox. 1899.

(b) "Surgery: A Treatise for Students and Practitioners." By Thomas Pickering Pick, Consulting Surgeon to St. George's Hospital, Senior Surgeon to the Victoria Hospital for Children, H.M. Inspector of Anatomy in England and Wales. London, New York, and Bombay: Longmans, Green, and Co. 1899.

of reference, containing a concise and practical account of the causes of surgical injuries and diseases, the signs by which they may be recognised, and the appropriate treatment to be adopted for their cure."

With so extensive a programme to be carried out, the responsibilities of an author are inevitably very great. It is only the enthusiastic lover of his profession who can fully appreciate the value of the teaching which is comprehended in this portly octavo of 1,176 pages.

In examining the contents of this representative textbook, we will begin with the very ordinary subject of fractures. On page 427, the subject of Fractures of the Scapula is introduced, and we are told that "Fracture through the body is almost always caused by direct violence, and the lesion is generally in the infra-spinous fossa." The fact is that fracture of the body of the scapula is hardly ever caused by direct violence—military practice, of course, excepted. The direct violence is applied to the spine of the scapula by a blow or fall, and the indirect result usually appears in the infra-spinous fossa. On page 431 we are told that separation of the lower epiphysis of the humerus is "very liable to be mistaken for dislocation of the radius and ulna, or for supra-condyloid fracture of the humerus." The fact that the passive mobility of the joint is increased in separation of the epiphysis puts the former injury out of the question; while the fact that *the lower epiphysis of the humerus does not include the condyles*, makes a confusion with the latter perfectly ridiculous. On page 433 we are told that "It would appear that in every case of Colles's fracture the upper fragment is driven into the cancellous tissue of the lower." This is a re-echo of the special view advanced by Voilemier, which will not for a moment bear the light of our knowledge of the subject in the present day. Of "Separation of the epiphysis of the head of the femur," we are told (p. 446) that "the symptoms are the same as those of fracture of the neck of the bone, but they occur in children, and the crepitus, if any exists, is of a soft character." The epiphysis of the head of the femur is but a very thin shell of bone beneath the articular cartilage; and, if separated, must lie, not only within the capsule, but at the bottom of the acetabulum, so that its simulation of a "fracture of the neck" is simply a physical impossibility. On page 459 we find a series of four diagrams illustrative of fractures near the lower end of the fibula. The fourth is meant to represent the displacement in Dupuytren's fracture. Readers of Dupuytren's graphic description know that in the injury which he specially described the astragalus is displaced completely outwards from below the lower end of the tibia, and then passes upwards on the outer side of the latter, carrying with it the lower fragment of the fibula, which is thus widely separated from the tibia by the whole width of the astragalus.

On p. 521, the subject of "Displacement of a Semilunar Cartilage" is introduced. We are there told that "This by no means uncommon accident was first described by Hey under the name of internal derangement of the knee-joint." As a matter of fact, Hey did not even indicate a suspicion that it was due to a displacement of one of these structures; he described clinical facts and symptoms with the acumen of a true observer of nature, and did not draw upon his imagination in the way in which subsequent "authorities" have done. We are gravely informed here that "sometimes a portion of one of the cartilages may be separated from all its connections and remain as a loose body in the joint. The varieties of the displacement are several: the cartilage may be separated from the head of the tibia by tearing of the coronary ligament, and may then be displaced either outwards or inwards; or the cartilage may be torn away from its anterior attachment, and be folded backwards into the intercondyloid notch." This description is enough to make a critic seriously ask himself the question, whether the writer has ever examined the structure of the knee-joint at all. The internal semilunar cartilage, which is well known to be the most frequent seat of "derangement," depends for fixation—not on the flimsy "coronary" ligaments, which merely support the synovial membrane and complete the "capsule" of the joint, but on the enormously strong osteal

attachments of the cornua, and the extensive and intimate adhesion to the whole breadth of the internal (deep) surface of the internal lateral ligament of the knee joint. Every person conversant with the anatomy of the knee must admit that such separation could not occur without so extensive destruction of the inter-articular structures as would render immediate reduction (i.e., relief and functional restoration) utterly impossible. Accordingly, it is simply ludicrous to find the statement made under the heading of "Treatment," that after extreme flexion, followed by sudden extension, "the displaced cartilage will generally slip into its place. The patient, if he is not under the influence of an anæsthetic, will at once be conscious that the displacement is reduced, and will again be able to move his leg." We would invite any earnest student of his profession to procure a healthy knee for dissection; and, during the process, endeavour to reconcile the above-quoted statements with his own observations and with one another.

We are told that many centuries ago a very wise man—evidently in a moment of intellectual ennui—expressed regret at the fact that of the "making of books" there was no end. The same source of sorrow ushers in the dawn of the twentieth century. But lest this review should also appear interminable, we will draw it to a close. We have offered a few small items of criticism. We will reserve the remainder for our notice of the second edition.

TWENTIETH CENTURY PRACTICE. (a)

THE completion of this phenomenal scientific undertaking now approaches within easily measurable distance. The publication of two more volumes will finish the colossal task which Dr. Stedman imposed upon himself with the unselfish heroism of a Crusader, and by the conduct of which he has won undying glory for himself, conferred honour on our profession throughout the world, and rendered suffering humanity at large his debtor—through all the years of the now dawning twentieth century; if not, indeed, throughout all time.

The present portly octavo of 703 pages includes the subjects of syphilis and leprosy—only. There are three articles by three authors; syphilis being subdivided into "acquired" and "inherited." When we mention that "Acquired Syphilis" is dealt with by Dr. E. Lang, of Vienna; "Inherited Syphilis" by Jonathan Hutchinson, of London; and "Leprosy" by Dr. Prince A. Morrow, of New York, we are but registering another item to the testimony, which we have throughout borne to the discriminating skill which Dr. Stedman has displayed in the selection of his staff.

The reputation of the writers on syphilis who are responsible for the articles in this volume makes us feel that our readers—as well as ourselves—would look upon any small criticism on our part as neither more nor less than a specimen of officious journalistic impertinence. We accordingly take leave of this part of our subject and our readers, feeling absolutely confident that nothing can go wrong which may by any possibility be attributable to the efficiency of the guides in whose hands they are left.

As "Leprosy" is so comparatively uncommon a disease in these islands, we have ourselves perused with interest and profit the magnificent article on this subject by Dr. Prince A. Morrow. His necessarily vast clinical experience in genito-urinary and cutaneous diseases is sufficiently testified by the fact that he is "Professor of Genito-Urinary Diseases in the University and Bellevue Hospital Medical College; Attending Physician to the Department of Skin and Venereal Diseases, New York Hospital; Surgeon to the City Hospital; Consulting Surgeon to St. Vincent's Hospital."

In this splendid and exhaustive essay the almighty *bacterium* assuredly receives "Benjamin's portion" of scientific attention. "Leprosy, according to Cornil, is the perfected type of bacterial disease." "Arning states that the bacilli seem to multiply in the bodies of dead

(a) "Twentieth Century Practice: An International Encyclopedia of Modern Medical Science by Leading Authorities of Europe and America." Edited by Thomas N. Stedman M.D., New York City. In twenty volumes Vol. XVIII. "Syphilis and Leprosy." London: Sampson, Low, Marston, and Company, 1899.

lepers months after they have been buried." "The only experiment claimed to be successful in inoculating leprosy in man was that of the convict Keanee, of Hawaii, who was inoculated by Arning in 1881, with pus laden with bacilli, and, in addition, a portion of a tubercular nodule was inserted subcutaneously. This man developed leprosy, from which he has since died." "The similarity of the tubercle and lepra bacilli, and the difficulty of differentiating the nodules of tuberculosis from the nodules of leprosy must be considered in appreciating the value of these experiments." "Recognising Hansen's bacillus as the active efficient cause of leprosy, it may be assumed that all the tissues of the body of the leper containing this organism constitute possible sources of infection; the condition of infection that the bacilli should be discharged from the body of the leper, brought in contact with and be capable of penetrating the tissue of a healthy organism in an opportune place favourable for its germination." We have every aspect of the relationship between bacteria and leprosy considered—in a space of about eighteen richly-furnished pages. Still, we are under the depressing influence of the statement made at the beginning of this section of "Etiology":—"It must be admitted, however, that the chain of evidence which connects the bacillus with the causation of leprosy is not so complete as in the case of certain other parasitic diseases, as for example tuberculosis and anthrax."

The author very summarily disposes of the preposterous "fish theory" of the origin of leprosy, so stoutly advocated—strangely enough—by a no less eminent a clinician than Mr. Jonathan Hutchinson. "The fallacy of the fish theory is proved by the fact that leprosy occurs among people who have never tasted fish, either because it was not obtainable or because it was forbidden by their caste or religion." The inhabitants of Kurdistan and Kashmere are mentioned, where leprosy is found, although fish diet is never used. The Kafirs are, we believe, a prominent example of the existence of leprosy among a people to whom the rules of caste forbid the use of fish as a food.

These are but cursory remarks on the magnificent article before us which we have read with perhaps more engrossing interest than any other in the *Encyclopædia* of which it forms so brilliant an item. We cordially recommend all our readers to go and do likewise.

KNOFF ON PULMONARY TUBERCULOSIS. (a)

THE observations contained in this book first appeared as a thesis entitled "Les Sanatoria, Traitement, et Prophylaxie de la Phtisie Pulmonaire."

To this thesis was awarded by the College of Physicians of Philadelphia the Alvarenga Prize for the year 1898, and now the reader has presented to him the thesis expanded into an interesting book on the sanitation, hygiene, hospitalisation, and treatment of tuberculous patients of all classes of society.

The author was first moved to the study of tuberculous disease by a long stay in Los Angeles, Cal. There he met with thousands of consumptives who flocked thither every winter, all believing that the glorious climate of South California alone would suffice to restore them to health. The result of observation was to impress upon Dr. Knopf's mind the great importance of distinguishing cases of tuberculosis, and observing how certain climates suited certain invalids according to the nature and stage of their malady.

The author visited, in both continents, some thirty sanatoria, special hospitals, and health resorts devoted exclusively to the treatment of pulmonary tuberculosis.

In England it appears that special hospitals for consumption have multiplied in greater proportion than in any other country. Sanatoria, on the contrary, till very

recently, were relatively rare in England, Germany taking the lead in this class of institution.

The short chapter of instructive data in the history of tuberculosis shows most painstaking research. We have given to us the views of Hippocrates and Aretæus, and are brought eventually to the history of the earliest efforts in sanatorium treatment as inaugurated by Dr. George Boddington, of Sutton Coldfield, Warwickshire, in 1840. The descriptions, with illustrations, of various sanatoria cannot fail to interest. Some of these buildings, as that of Drs. Westrey Battle and John Ross, at Asheville, look very homelike and inviting, as also does the one at Citronelle, Ala., kept by Dr. C. Klebs. Others have a look as if they meant business rather than beauty.

In Chapter IX. is given a tabulated list of Sanatoria. The author's remarks on treatment are valuable, especially his experience of the pneumatic cabinet in the treatment of pulmonary tuberculosis. We are surprised to find no mention made of the treatment of pulmonary cavities and dilated bronchi by inhalations of creosote in a chamber devoted to that purpose. Such a chamber as devised by Dr. Arnold Chaplin, has for years been in use at the City of London Hospital for Diseases of the Chest at Victoria Park, and has afforded very satisfactory results. Treatment by tuberculin and culture serums is disposed of in a couple of pages, receiving about as much notice as the subject is at present entitled to get.

The chapters on the management of consumptives in health resorts and in special hospitals are full of important and valuable directions with a view to prevent any chance of contagion. We fail to find any remarks on the notification of tuberculosis, and we can hardly think that so experienced and suitable a writer as Dr. Knopf would be found among the advocates of this rather severe measure, likely to depress the unhappy invalid and prejudice much his chance of recovery. If due care can be paid to all that is said as to the communicability of pulmonary tuberculosis (in this chapter, p. 47, are some disagreeable facts for cigar smokers), and these are precautionary measures, there seems very little to fear from the limited character of the contagious element in tuberculosis. The book is one to cheer and encourage both patient and physician, not by mere impressions of the author himself, but by truths and experience carefully recorded from personal observation and from carefully selected authorities, all of which are recorded for reference by the reader. One thing in this otherwise excellent work by no means commends itself to us, it is the use of the term "phthisis therapist" in place of physician. If a doctor told us he was a phthisis-therapist it certainly would not add to our confidence in his knowledge.

WILLIAMSON'S SYPHILITIC DISEASES OF THE SPINAL CORD. (a)

A GREAT amount of instruction on syphilitic diseases of the spinal cord can be gleaned from the perusal of Dr. Williamson's little book, in which he includes a number of observations, both clinical and pathological, made by him during ten years at the Manchester Royal Infirmary. Especially interesting are the sections on meningitis and on meningo-myelitis (the latter of which contains some excellent illustrations); also those on acute paraplegia, on Erb's syphilitic spinal paralysis (both embellished with pathological coloured plates). It seems, however, invidious to particularise any portion of the work, as all the sections teem with evidence of laborious research and intelligent observation; but it is a great pity that the author has neglected to correct his proofs, as he has allowed not only printers' errors, but also several grammatical mistakes, to creep into his text.

(a) "Pulmonary Tuberculosis: Its Modern Prophylaxis and the Treatment in Special Institutions and at Home." Alvarenga Prize Essay of the College of Physicians of Philadelphia for the year 1898, revised and enlarged. By S. A. Knopf, M.D. (Paris and Bellevue, N.Y.). Octavo. Price net 3dols. Philadelphia: P. Blackiston's Son and Co.

(a) "Syphilitic Diseases of the Spinal Cord." By R. T. Williamson, M.D. Lond., M.R.C.P. Manchester: Sherratt and Hughes, P. 127.

New Articles.

XEROFORM—A SUBSTITUTE FOR IODOFORM.

XEROFORM, which is introduced as an advantageous substitute for iodoform, is a yellow, neutral, insoluble powder, in a state of fine division, which is reputed to possess markedly drying and healing properties. It presents the advantages *inter alia* over iodoform of not being liable to cause toxic symptoms consequent on absorption, and of being devoid of any objectionable odour. Its formula is $C_6H_2Br_3 \cdot O \cdot Bi \cdot O$. Strong acids and alkalis split it up into bismuth oxide and tribromophenol. When applied directly to wounds or suppurating surfaces it excites no reactive inflammation, and it is not liable to undergo deterioration by keeping. It can, moreover, itself be sterilised by heat, as it is practically non-volatile, and it appears to be possessed of powerful germicidal properties. In virtue of its non-toxicity it may be given internally as an intestinal antiseptic. Lastly, xeroform is hæmostatic and analgesic, the latter quality rendering it specially suitable for dressing burns, and it is said to give such excellent results in the treatment of weeping eczema, intertrigo, ulcus cruris, and ulcus molle, that some recent writers consider it as almost a specific against these diseases. The clinical evidence in support of the claims advanced on its behalf is considerable, and as its advantages are unalloyed by any corresponding drawback it may safely be recommended for a trial.

MERCUROL.

MERCUROL, a sample whereof has been sent us for examination by Messrs. Parke, Davis, and Co., is a fine homogeneous powder, of a greyish-white colour. Its composition is interesting, seeing that it is a stable organic compound of mercury, of which it contains about ten per cent. It is obtained by the action of nucleic acid (known as nucleol obtained from yeast) on freshly precipitated mercuric oxide. The latter is gradually dissolved, and, on the addition of alcohol, is precipitated in the form of nucleinate of mercury. It is also interesting to note that silver, copper, and iron oxides react in a similar way with nucleol. These compounds are all soluble in water, and their solutions do not precipitate a firm insoluble compound with albumen, nor is mercurool decomposed on the addition of an alkali.

Mercuriol is reported to be a powerful germicide, and its solutions, rendered stable by the addition of half per cent. of chloride of sodium, have been used with marked success in the treatment of purulent conjunctivitis, corneal ulcer, and phlyctenula, as well as in suppurative otitis.

This organic compound of mercury appears to offer very special advantages as an antiseptic and germicide, whether used as a powder, in solution, or as an ointment.

VON HEYDEN'S FOOD.

THIS food is a fine, reddish-yellow powder, with a faint, characteristic, but by no means disagreeable, odour. It consists of albumenoids in a form capable of prompt assimilation. Analysis gives the following results:—Nitrogen, 13.65; mineral matter, 6.04, and water, 2.36 per cent. The relatively small proportion of water, as compared with other similar products, is remarkable. It is distinguished from Tropon in that the latter is an insoluble albumenoid, and from Somatose in a somewhat reduced solubility, in fact, Heyden's food occupies a position intermediate between albumen and somatose.

This product is intended to be taken only in addition to the ordinary diet, and never as a substitute. It should be dissolved in some liquid aliment, preferably cocoa, and thus prepared it is capable of immediate absorption and affords a valuable means of supplementing the nitrogenous element in the dietary.

Heyden's food is one of a series of new alimentary products which merit the careful attention of practitioners, inasmuch as they appear to provide valuable additions to our resources in therapeutic dietetics.

THERMOGENE.

THERMOGENE is cotton wool charged with capsicum, and when maintained for some time in contact with the skin it provokes mild counter-irritation, without any risk of blistering and without causing too pronounced burning or smarting. It would seem to be specially adapted for the treatment of chronic inflammatory and rheumatic conditions, of joints, for instance; as well as for the chest, where its action can be maintained indefinitely. The ease with which it can be employed and the cleanliness of its application ought to secure for it a field of usefulness. It is manufactured by Messrs. Fassett and Johnson, of 32, Snow Hill, E.C.

Medical News.

Royal College of Surgeons in Ireland—Winter Fess' on 1899 1900 Prize List.

Descriptive Anatomy.—Junior: J. S. Shiell, 1st prize, £3 and medal; J. J. Connolly, 2nd prize, £1 and certificate. Senior: J. Cockburn, 1st prize, £3 and medal; R. W. Burkitt, 2nd prize, £1 and certificate.

Practical Anatomy.—First year: Miss J. C. Hargrave, 1st prize, £3 and medal; A. N. Crawford, 2nd prize, £1 and certificate. Second year: E. C. Byrne, 1st prize, £3 and medal; R. G. Allen, 2nd prize, £1 and certificate. Third year: A. Charles and T. A. Dillon (equal), 1st prize, £3 and medal; C. W. Ewing, 2nd prize, £1 and certificate.

Practice of Medicine.—A. Charles, 1st prize, £3 and medal; J. F. Peart, 2nd prize, £1 and certificate.

Surgery.—C. W. Ewing, 1st prize, £3 and medal; J. F. Peart, 2nd prize, £1 and certificate.

Midwifery.—W. R. Meredith and J. F. Peart (equal), 1st prize, £3 and medal; Miss M. J. Shire, 2nd prize, £1 and certificate.

Physiology.—J. P. Ziervogel, 1st prize, £3 and medal; R. W. Burkitt, 2nd prize, £1 and certificate.

Chemistry.—B. H. Peters, 1st prize, £3 and medal; F. O'D. Fawcett, 2nd prize, £1 and certificate.

Pathology.—J. M. S. Levis, 1st prize, £3 and medal; T. J. Tallon, 2nd prize, £1 and certificate.

Physica.—Miss J. C. Hargrave, 1st prize, £3 and medal; M. Lochrin, 2nd prize, £1 and certificate.

Medical Scholarships for Women.

Two additional entrance scholarships are offered in connexion with the London (Royal Free Hospital) School of Medicine for Women. The St. Dunstan's Charity promises one of £60 a year for three years. It will be awarded next September on the result of the Arts entrance examination. The other new scholarship is one of £90 for one year only. It will be known as the Singleton Scholarship, and it will be awarded on the results of the Preliminary Science Examination (University of London) in the summer of 1901. The holder of the Singleton scholarship will be required to have taken the science training and to go through the whole medical curriculum at the London School of Medicine for Women. She must enter the school in May or October of the present year in order to be ready for the examination in 1901. The scholarship will give the holder a free ticket for the entire course of instruction in the school for four years. She will still have to pay for practical instruction at the Royal Free Hospital, and for any extra classes she wishes to take at the school or elsewhere.

The Midwives' Registration Bill.

AT A MEETING of the West Kent Medico-Chirurgical Society recently held at the Royal Kent Dispensary, the president, Dr. C. J. Parke, occupied the chair. Dr. F. S. Toogood introduced the discussion, and moved the following resolution:—"That this meeting of the West Kent Medico-Chirurgical Society, whilst cordially welcoming fully-qualified lady doctors, protests against the proposed Midwives' Registration Bill, as tending to create an inferior order of midwifery practitioners, and as being contrary to the spirit of the Medical Acts, which were designed to protect the public in general and the poor in particular."

That this meeting thanks the council of the society for co-operating in convening the meeting to resist the registration of midwives, and will support the council (pecuniarily or otherwise) in carrying on that resistance as resolved by the South-East London meeting." The resolution was seconded by Dr. Chisholm Williams and strongly supported by the President, Drs. Barnett, Hart, Herschell, Anderson, Weekes, Keay, and Henry. It was carried unanimously and ordered to be forwarded to members of Parliament and the press.

Another Victim of Morphia.

An inquest was recently held in London on the body of Mr. Nevelle Percy Francis Toller, M.R.C.S., L.R.C.P., who was found dead in bed apparently as the result of an overdose of morphia, hypodermic syringes and an ample supply of morphia being found on the table.

The Late Dr. R. Glasgow Patteson.

The following resolution was passed at a meeting of the Medical Board of Meath Hospital:—"That the members of the Medical Board of the Meath Hospital desire to record the feelings of deep sorrow with which they have heard of the lamented death of their talented colleague, Dr. Robert Glasgow Patteson, and they hereby convey to Dr. Patteson's mother and the various members of her family an expression of their profound sympathy with them in so touching and melancholy a bereavement." The resolution was proposed by Sir P. C. Smyly, and seconded by Dr. J. W. Moore, President R.C.P.I.

Assault on a Medical Man.

DR. F. TOMLINSON, of Bradley, was recently the victim of an outrageous assault at the hands of a burly labourer, who summoned him to attend his wife on the "your services or your life" principle. This irascible husband was sentenced to six weeks' hard labour, subsequently reduced to a month, as an intimation that the law views with disapproval such attempts to coerce medical men to lend their services when indisposed so to do.

PASS LISTS.

Conjoint Board of the Royal Colleges of Physicians and Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow.

THE quarterly examinations of the above Board in Edinburgh were concluded on April 10th, with the following results:—

First examination 5 years' course. Of 24 candidates entered the following 9 passed the examination:—

William Hawkey Woodger, Newcastle-on-Tyne; Lilian Mary Grandin, Jersey; William Black Hendry, Edinburgh; Leo Ferdinandi Bianchi, Tunbridge Wells; Joseph Stark, Forth; Vivian St. John Croley, India; John St. Aubyn Maughan, Grimsby; William James Purves Hartlepool; and Charles Ewbank Foot Gaitskell, St. Leonards-on-Sea, and 3 passed in physics, 6 in elementary biology and 2 in chemistry.

Second examination, 4 years' course. Of 5 candidates entered the following 4 passed the examination,

Samuel Graham Kinlock, Manchester; Patrick James Kerwin; Cork; James Levack, Caithness; and Robert Ellsworth Turner, Rock Ferry.

Second examination, 5 years' course.—Of 20 candidates entered the following 14 passed the examination:—

Cecil Richard Martin, Calcutta; John O'Regan, Mitchelstown; William Sam Rainey Dick, Ballynally; Reginald Herbert Brierley, Rochdale (with distinction); John Dick, Edinburgh; Herbert Frederic Walker, Tasmania; Hamilton Watson, Shetland; William John Shorten, County Cork; William Vincent Sutton, Cork; William John Gray, Portobello; Henry Carlaw, Aldershot (with distinction); James Harvey Stewart, Alford (with distinction); Robert Walter Joseph Pearson, Ennis; and Hermann Sperling Christoffel, Ceylon.

Third examination, 5 years' course.—Of 25 candidates entered the following 16 passed the examination:—

Harry Findlater Wilkin, St. Helens, Lancs. (with distinction); Alec Boswell Timms, Australia; Arthur Thomas Hoskins, Victoria; Gopal Chander Ghose, India; Herbert Ernest Jardine Batty, India; Thomas Huston, Carrickfergus; William Henry Eden Brand, London; Robert Thompson, County Derry; Helen Mary Serjeant, Huntingdonshire; Kenelm Cobham Edwards, Felham; William Cowan Brown, Gateshead; Benjamin Gouing, Salisbury; Alfred Lambie White, Dundee; John Walker Wood, Edinburgh; James Thomas O'Connor, Edinburgh; and George Kee, Greenock; and two passed in Materia Medica.

Final examination.—Of 59 candidates entered the

following 30 passed the examination and were admitted L.R.C.P.E., L.R.C.S.E., and L.F.P. and S.G.:—

Fanny Wood, Ireland; Joseph Henry Bennett, Bombay; William Daley, Buncorn; Robert Orford Jones, Llanfyllin; Geoffrey Carlstrom Hobbs, London; George Day, Norwich; Charles Henry Farquharson, Jamaica; William Pattullo, Alvyth; Robert McLaren, Edinburgh; Ralph Frankland Morris Fawcett, Whitehaven; Elizabeth Morton Johnston, Edinburgh; Jessie Jane Graham, Dunfermline; Andrew Graham, Peebles; Walter Percy Warburton, Leeds; William Thomas Finlayson, Edinburgh; Francis Wilfred Harlin, Brisbane; George Potts, Cheshire; Donald McDonald Robertson, Perth, On ario; Victor Adolphus Hart, Barrie, Ontario; Charles Glenfanning Thomson, Hiawatha, Ontario; Thomas Malcolm Russell Leonard, Bangalore; William Arthur Benson, Co. Durham; Edith Anna Wynne-Edwards, Montgomeryshire; Henry Francis Stilwell, Hillingdon; John Robertson, Perthshire; James Henry Moag, County Down; Austen Andrew Bearne, Devonshire; Albert Ernest Sikeld, Victoria; Edward Bennett, Lancashire; and Vivian Stjohn Croley, India; and two passed in Medicine and Therapeutics, one in Surgery and Surgical Anatomy, two in Midwifery, and four in Medical Jurisprudence.

The following candidates have passed the respective examinations:—

First Examination, five years' course.—Bertram H. Watch, John Watson, Thomas William Roberts Ian Campbell, Thomas Edward Fittercroft.

First Examination, four years' course.—William Pritchard-Airey, John Charles Grant, St. Clair G. Ballenden, Lewis Edward Jarrett, Edwin A. Shanks.

Second Examination, five years' course.—William George Macdonald, John Bertram L. S. Scott, Albert Edward Griffith, Richard Lewis, James Walsh, Timothy Foley, Charles Alexander Bruce-Whyte, Evan Owen Roberts, Gerald William Smithwick, Thomas Russell.

Second Examination, four years' course.—Herbert Davis Pitt, William Pritchard-Airey, John Dunlop, Michael Lyons, Angus McCleod.

Third Examination.—John Baeside Smith, John M'Intyre, Terence Aloysius Welch, William Henry Duncan, Kennedy Joseph O'Brien, Harry Miller Roberts, Thomas Ernest Hartly, John William Isbister, Archibald MacMillan, Anthony H. Corley, Hugh Williams, Louis Edward Staynes, Hugh De Mel.

Final Examination (and admitted Licentiates of the three co-operating Colleges):—John Campbell Douglas, Thomas Blane Adam, David Speid C. Reid, Helen Sinclair Macdonald, William Airlie Olvey, John Thomas Moore, Sydney S. Menzies, Arthur Harold, Wilson, Matthew O'Halloran, Gangakanta Nag, Alexandra Fraser Jacq, Owen Felix M'Carthy, Sydney Gerald Gomes, William Mason.

Royal University of Ireland.

The following candidates have passed the Second Medical Examinations:—

UPPER PASS

Samuel K. Adams,* Patrick Dwyer,* Norcott D'E. Harvey,* James Mc A. Holmes, Thomas D. Liddle,* Frederick C. Smyth,* Samuel Stockman,* Joseph H. Thompson, Cecil B. F. Tivy, Samuel H. Whyte.

Candidates marked thus * recommended for honours.

PASS.

Simon Broderick, Ernest Clements, Florence M. M. Condon, John W. Dale, Alexander Dick, Mary E. Jeremy, George Kelly, Samuel J. Kilen, Arthur D. O'Carroll, Patrick M. O'Dwyer, Ernest D. Rutherford, William J. Sheehan, William A. Simpson, James E. Wilson.

Third medical examination:—

UPPER PASS.

Marion B. Andrews,* Albert L. Black, B.A., John Clements, Samuel B. Hunter, B.A., Patrick O'Doherty,* Walter Phillips, B.A., *Andrew J. Quirk.

*Recommended for Honours.

PASS.

Henry M. Agnew, Robert Best, Catharine L. Boyd, William H. N. Bright, David E. Campbell, Robert H. Caughey, B.A., Joseph Camker, George Ebrill, John H. Ferris, Augustine T. Frost, John F. Harrold, Patrick Heffernan, B.A., William M. F. Keogh, Maurice J. Macauley, John McMurray, Samuel B. W. Moore, William F. O'Connor, John J. O'Hare, Henry Ross, William B. Simpson, Frederick W. Stewart, B.A., John J. Walsh.

Conjoint Examinations in Ireland.

The following candidates have passed the Second Professional Examination:—

Passed in All Subjects.—F. G. McCaughey, W. J. O'Doherty, C. Robinson, F. C. York.

Completed the Examination.—W. H. Anderson, J. E. Brereton, C. H. Bryan, H. M. Clarke, M. T. Donovan, C. D. Downing, W. J. Greehy, J. P. Falls, Tho. Farrell, J. P. Fitzmaurice, A. H. B. Hartford, B. E. Humfrey, T. E. Johnston, J. B. Logan, J. Murphy, J. Murray, E. P. McDonnell, M. A. A. O'Brien, J. P. Ryan, W. Scott, Chr. Waters.

In Anatomy.—A. H. B. Duncan, J. Dwyer, B. T. Gordon, T. Keogh, P. McDermott, J. P. Ziervogel.

Physiology.—J. J. Gibney, T. Keogh, J. J. M. Juerney, M. C. Sage, F. M. Sheridan, J. P. Ziervogel.

Materia Medica.—E. M. Atkin, B. D. Gibson, E. Opody, P. M. Sheridan, S. H. Raverty.

Histology.—J. Dwyer, H. B. Evans, B. D. Gibson, B. J. Gordon, T. Keogh, P. McDermott, E. Opody, J. P. Ziervogel.

Omitted from list of First Professional Examination:—

Completed Examination.—J. M. G. Foles.

Passed in Pharmacy.—D. de C. Opady.

Notices to Correspondents, Short Letters, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

LOCAL REPORTS AND NEWS.—Correspondents desirous of drawing attention to these are requested kindly to mark the newspapers when sending them to the Editor.

READING CASES.—Cloth board cases, gilt lettered, containing

REPRINTS.—Authors of papers requiring reprints in pamphlet form after they have appeared in these columns can have them, at half the usual cost, on application to the printers before the type is broken up.

AN EXTRAORDINARY TESTIMONIAL.

The Chemist and Druggist prints a testimonial purporting to emanate from Mr. Ashcroft Ellwood, L.R.C.P., M.R.C.S., D.P.H. Cantab., of Dartford, Kent, in favour of a certain quack "croup lotion," to the efficacy whereof he bears witness in the following terms:—"I have no hesitation in saying that the preparation is a valuable remedy for the cases in which it is prescribed, and I think its application could be far more generally used, especially in chest complaints and stiff neck arising from cold or draught. I put it to a practical test upon a patient suffering from laryngitis accompanied by aphonia, and in less than six hours the throat was relieved and the voice returned." Well may our contemporary describe it as "exceptional," and the only plausible explanation is that Mr. Ellwood has not shaken off habits of thought and conduct begotten of his former association with the *Chemists Assistants' Association*. Such an act, judging by the canons of professional etiquette, cannot but bring discredit on its author, although he may escape disciplinary punishment.

REMARKS.—We have indeed received a copy of the report, but as it is marked "private and confidential," we do not feel justified in making use of the information contained therein.

GENERAL.—You will find practical directions in any manual of bacteriology. The process takes about half an hour, and if you cannot spare the time and labour necessary to this method of diagnosis, the Clinical Research Association will gladly assist you.

DR. ELDER is thanked for his communication; his suggestion shall be complied with.

DR. A. G.—We are having an engraving made of the case, the paper will appear as soon as this is ready.

Meetings of the Societies and Lectures.

WEDNESDAY, MAY 2ND.

OBSTETRICAL SOCIETY OF LONDON.—8 p.m. Specimens will be shown by Dr. Tate and others. Papers: Dr. T. Wilson: The Relations of Organic Affections of the Heart to Fibro-myoma of the Uterus.—Mr. A. Doran (President): A Case of Extrauterine Gestation in which Fetal Death occurred at the Eighth Month after Spurious Labour, Abdominal Section two months later.

THURSDAY, MAY 3RD.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road).—Paper:—Mr. J. D. Malcolm: The Selection of Cases for Abdominal Section.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.—8 p.m. Clinical Evening. Cases. 8.30 p.m. Mr. Nettleship: Note on Opaque Nerve Fibres of the Retina.—Mr. Critchett: Optical Irregularities for Lenticular Cataracts.—Mr. F. M. Ogilvie: Eye Changes in a case of Bullet Wound of Head.—Mr. R. Bickerton: Case of Protrusion of Eyeball on Stopping.—Mr. W. T. Lister: Affection of Choroid.—Mr. Juler: (1) Emile Berger's Binocular and Stereoscopic Lens; (2) Proptosis with Ophthalmoplegia Externa.—Mr. T. Collins: Case with Congenital Notch in the Margin of each Lower Lid.—Mr. Higgins and Mr. Ormond: Specimen of Sarcoma of Choroid.

FRIDAY, MAY 4TH.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY (West London Hospital, Hammersmith, W.).—Pathological Specimens: Mr. L. Bidwell: A Series of Gall-stones. Papers:—Dr. B. Blacker: Treatment by Ultra-violet Rays.—Dr. S. Taylor: Notes on Two Cases of Membranous Colitis.—Dr. L. Dobson: (1) Notes on a Case of Foreign Bodies in the Mammary Gland; (2) A Case of Impacted Fracture of the Head of the Femur complicated by Infantile Paralysis.

WEST KENT MEDICO-CHIRURGICAL SOCIETY (Royal Kent Dispensary, Greenwich Road, S.E.).—8.45 p.m. Mr. C. J. Parke: What shall we do with our Inebriates? (Presidential Address.) To be followed by a Smoking Concert.

LARYNGOLOGICAL SOCIETY OF LONDON (20, Hanover Square, W.).—5 p.m. Cases will be shown by Dr. W. Williams, Dr. L. Turner, Dr. I. Lack, Dr. Tilley, Dr. Bronner, Dr. J. Horne, Mr. C. Symonds, Mr. Paget, and Mr. Waggett.

SOCIETY OF ANÆSTHETISTS (2, Hanover Square, W.).—8.30 p.m. Casual Communications. The Ordinary Meeting will be followed by the Annual Meeting for Election of Officers, &c.

ROYAL ACADEMY OF MEDICINE OF IRELAND.—SECTION OF PATHOLOGY.—Papers:—Sir C. Nixon: Cases of Addison's Disease. The Secretary (E. J. McWeeney, M.D.): (1) On Spontaneous Rupture of the apparently healthy Oesophagus; (2) A Case of Congenital Cystic Kidneys. Exhibits.—Sir C. Nixon and Dr. E. J. McWeeney: Naked Eye and Microscopic specimens from Cases of Addison's Disease. Dr. E. J. McWeeney: (1) Rupture of Oesophagus; (2) Congenital

Cystic Kidneys; (3) Specimens from Cases of Cerebro-spinal Meningitis. Drs. R. Travers Smith and H. C. Earl: Organs from a Case of Spleno-medullary Leukæmia. Dr. A. C. O'Sullivan: Syphilitic Growths of Heart (two cases); (2) Specimens of Cerebro-spinal Meningitis; (3) Ulcerative Endocarditis. Dr. J. Knott: Specimens of Fractures of Ribs, Vertebrae, Clavicle Patella and Astragalus; Fractured Fractures of Articular Surface of Patella and of Inferior Articular Surface of Radius, &c.

Appointments.

BIRD, G. W. HARVEY, M.A., M.B., B.C. Cantab., M.R.C.S., L.R.C.P., Surgeon to the Brigwater Infirmary.
BOAKE, SAMUEL, L.R.C.P., L.R.C.S., Medical Officer of Health for Ilminster, and also Medical Officer for the No. 1 (Ilminster) District by the Chard Board of Guardians.
BOX, CHARLES RICHARD, M.D., B.S., B.Sc. Lond., M.R.C.P., F.R.C.S., Assistant Physician to St. Thomas's Hospital.
JONES, D. WILLIAMS, L.R.C.P., L.R.C.S. Edin., L.S.A., Medical Officer and Public Vaccinator to the Rotherham No. 1 District.
MAIDLOW, W. H., M.D. Durh., B.S., F.R.C.S., Medical Officer of Health by the Ilminster District Council.
MASSET, D., L.R.C.P., L.R.C.S., Medical Officer of Health for the Berrier Sanitary District of the Forden Union.
MCCABE, H. J., M.B., C.M. Irel., Assistant Medical Officer to the County Down Infirmary.
ROBERTS, J. L., M.D. Lond., B.Sc., F.R.C.S. Eng., Honorary Physician Stanley Hospital, Liverpool.
WALKER, J. D., M.B., C.M. Aberd., Medical Officer for the Fontmell Sanitary District of the Shaftesbury Union.
WOOD, JAMES MILLER SWANSON, M.B., Ch.B., Assistant Medical Officer to the James Murray's Royal Asylum, Perth.

Vacancies.

City Asylum, Nottingham.—Second Assistant Medical Officer, unmarried. Salary £150, with board, apartments, and washing.
County Asylum, Rainhill, near Liverpool.—Assistant Medical Officer to act as Locum Tenens for about four months during the summer. Salary £3 3s. per week, with furnished apartments and board.
Dewsbury and District General Infirmary.—House Surgeon. Salary commencing £80 per annum, with board, residence, and washing.
Glamorgan County Asylum, Bridgend.—Junior Assistant Medical Officer. Salary £150, with board, apartments, washing, and attendance.
Ripon Dispensary and Cottage Hospital, Ripon.—Resident House Surgeon and Dispenser, unmarried. Salary commencing at £70, with board and lodging.
Staffordshire General Infirmary, Stafford.—House Surgeon for two years. Salary £120 per annum, with board, lodging, and washing. Also Assistant House Surgeon. Salary £80 per annum, with board, lodging, and washing.
Stockport Infirmary.—House Surgeon. Salary £100 per annum, with residence, board, and washing. Also Assistant House and Visiting Surgeon. Salary £70 per annum, with board, washing, and residence.
Wolverhampton and Staffordshire General Hospital.—House Physician. Salary £100 a year, with board, lodging, and washing.

Births.

CHEYNE.—On April 28th, at 75, Harley Street, London, W., the wife of W. Watson Cheyne, F.R.C.S., F.R.S., of a daughter.
HORTON-SMITH.—On April 27th, at 8, Upper Westbourne Terrace, London, the wife of Percival Horton-Smith, M.D., F.R.C.P., of a daughter.
TWNING.—On April 22nd, at Holm Leigh, Salcombe, South Devon, the wife of V. W. Twining, M.B., of a daughter.

Marriages.

FARNFIELD-SIMMONDS.—On April 24th, at Dorchester Abbey, Oxon, William Walter Farnfield, M.R.C.S., L.R.C.P., of Mere, Wilts, to Elizabeth Esther Simmonds, eldest daughter of J. A. Simmonds, of Belvedere, Kent.
JOB-FREEMAN.—On April 25th, at Kirkly Church, Lowestoft, Henry Percy Job, M.R.C.S. Eng., L.R.C.P. Lond., only son of Samuel Job, Esq., J.P., surgeon, Newark, Notts, to Geraldine Marie Cecilia Freeman, second daughter of the late F. G. Freeman, Esq., of Great Yarmouth.
MURRAY-BOWER.—On April 28th, at St. Martin's Church, Scarborough, John G. Murray, L.R.C.P., L.R.C.S. Ed., son of Ivor Murray, M.D., J.P., to Norah May Oakes, daughter of Edwin Bower, of Scarborough.
POOLE-SWIRE.—On April 28th, at St. Leonard's Church, Newark, John Copeland Poole, M.R.C.S., of Hampton Wick, to Margaret daughter of the late Rev. F. Swire, Rector of Elston, and of Mrs. Swire, of Newark.

Deaths.

AINLEY.—On April 24th, at Bournemouth, Daniel Ainley, M.R.C.S., M.O.H., County Borough of Halifax, aged 65 years.
ARCHDALL.—On April 20th, in London, Henry Stewart Archdall, M.R.C.S., L.R.C.P., late surgeon R.N., aged 32 years.
ELLIS.—On April 25th, at his residence, Minsterworth, near Gloucester, George Viner Ellis, F.R.C.S., late Professor of Anatomy, University College, London.
HULSEBERG.—At Rhodesia, South Africa, of fever, Harold Edwin, son of Surgeon Lieut.-Colonel Hulseberg, R.A.M.C., retired, aged 24.
JEFFREYS.—On April 21st, suddenly, at Brighton, Richard Parker Jeffreys, M.R.C.S., aged 59 years.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXX.

WEDNESDAY, MAY 9, 1900.

No. 19.

Original Communications.

ORGANIC IRON IN SECONDARY ANÆMIA.

By WILLIAM MURRELL, M.D., F.R.C.P.,

Physician to, and Joint Lecturer on Medicine at, the Westminster Hospital; Examiner in the University of Glasgow.

SOME months ago my attention was called to a form of organic iron prepared by a very ingenious process. Spinach was grown on a ferruginous soil—in France, if I remember rightly—and from the crop a liquid extract was prepared. What it was called I do not remember, nor is it a matter of much importance. It is possible that there may be several preparations made on these lines, but that I do not know. At all events the particular product submitted to me was a dark green fluid, having a pungent and an aromatic taste, probably due to the addition of flavouring agents. I was told that chemically it gave the reaction of iron salts, and that the iron was present in the form of a malate.

It so happened that at this particular time I had in the Hospital a patient suffering from well marked secondary anæmia, and I determined to give it a trial. She was a still-room maid, 29 years of age. When she was 19 she had a very profuse period, which left her so weak that she had to go to St. George's Hospital, where she remained for three weeks. At the age of 22, and again at 25, she had similar attacks which necessitated treatment. A fortnight before admission she had a profuse uterine hæmorrhage lasting for some days, during which she lost a very considerable quantity of blood. She remained in bed until the period ceased, but it left her so weak, and she fainted so frequently on the slightest exertion that she had to come to the Hospital.

On admission she presented every indication of profound anæmia. She was kept in bed, and a few days later her blood was submitted to examination.

The following is the report furnished by the Westminster Hospital Clinical Laboratory under the direction of Dr. Lazarus Barlow:—

Blood taken from finger 2.30 p.m. Drop pale and watery. Hæmoglobin 65 per cent. Erythrocytes, 3,570,000 per cmm. Hæmoglobin value of erythrocyte 78 per cent. Leucocytes 8,800 per cmm.:—Finely granular oxyphil cells, 63 per cent.; coarsely granular oxyphil cells, 3 per cent.; hyaline cells, 32 per cent.; lymphocytes, 2 per cent. One nucleated erythrocyte was seen in the blood film.

From this it will be seen that the case was one of combined oligocythæmia and oligochromæmia.

She was then placed on the organic iron preparation in half ounce doses three times a day. At the expiration of a fortnight there was considerable improvement in her general condition, and her blood was again examined with the following result:—

Blood taken at 12 noon. Droplet rather pale Hæmoglobin, 60 per cent. Erythrocytes, 4,560,000 per

cmm. Somewhat irregular in size. Leucocytes, 9,760 per cmm. in the following percentages:—Finely granular oxyphil cells, 59 per cent.; coarsely granular oxyphil cells, 4 per cent.; hyaline cells, 25 per cent.; lymphocytes, 12 per cent.

It will be seen that her red corpuscles had risen from 3,750,000 to 4,560,000 per cmm., or practically to normal; but that there was also a rise in the white corpuscles from 8,800 to 9,760 per cmm. There was no improvement in the hæmoglobin, which had fallen from 65 to 60 per cent.

The oligocythæmia had disappeared, but it was now a case of uncomplicated oligochromæmia.

On the day following this observation the patient menstruated, but the period was of short duration and normal in quantity.

The organic iron was now discontinued, and the patient was given 5 grns. of exsiccated sulphate of iron in pill three times a day. She was kept in bed, and no alteration was made in the diet. At the expiration of a fortnight another observation on the condition of the blood was made, with the following result:—

Drop taken 2.30 p.m. Flowed easily and of fair colour. Red blood corpuscles 4,500,000 per cmm., rather irregular in size and shape. A few nucleated red corpuscles present. Leucocytes 8,000:—Finely granular oxyphil cells, 52 per cent.; coarsely granular oxyphil cells, 3 per cent.; hyaline cells, 30 per cent.; lymphocytes, 15 per cent. Hæmoglobin, 78 per cent.

Although there had been no further increase in the number of red blood corpuscles, which could not have been expected seeing that they had already reached the normal—there was a marked improvement in the hæmoglobin, which had risen from 60 to 78 per cent. This is especially satisfactory when it is remembered that there are comparatively few cases in which the hæmoglobin reaches its nominal maximum.

From these observations I think it may be fairly concluded that although organic iron is undoubtedly useful in cases of secondary anæmia, it is less efficacious than the inorganic salts of iron. This is in accordance with the teaching both of Ringer and of Stockman. I had an opportunity of submitting the results to Prof. Stockman, and he agrees generally with the conclusion. In one of his papers he says:—"Of one thing I feel convinced, namely, that in chlorosis the ordinary inorganic preparations of iron cure much more quickly than organically combined iron does. Patients fed on even a rich and varied diet, containing plenty of organic iron, do not as a rule recover until inorganic iron is administered. I have tested this frequently, and have no doubt that it holds good in the great majority of cases, although some cases of chlorosis do recover spontaneously, and without any treatment. That is on the iron of the food alone."

It would seem that a diet rich in organic iron does not increase the percentage of hæmoglobin, although it would be anticipated that it would do so. This in no way detracts from the credit due to the originator

of the "spinach-iron" preparation. Spinach is a useful laxative, and we all recognise the necessity of giving laxatives or purgatives with iron in the treatment of anæmia.

In conclusion, I may say that I have not that implicit faith in Bland's pill in the treatment of anæmia which is shown by many people. I believe that far better results are obtained from a five-grain pill of exsiccated sulphate of iron taken three times a day. It is essential, however, that the pill should be made up with simple syrup or syrup of glucose, and not with a vegetable extract. Made with syrup it disintegrates as soon as it reaches the stomach, whilst the pill made with a vegetable extract forms a sticky mass which adheres to the mucous membrane of the stomach, where even if it does not produce a gastric ulcer it gives rise to a great deal of pain and discomfort.

SUCCESSFUL CASE OF EXCISION OF THE CÆCUM, WITH END-TO-END ANASTOMOSIS. (a)

By FREDERICK HOLME WIGGIN, M.D.,

President of the New York County Medical Association; Visiting Gynecologist to the New York City Hospital; Surgeon to St. Elizabeth's Hospital, &c., New York City.

On February 5th, I was called by Dr. D. R. Rodger, Woodbury, Conn., to see G. S., a married woman, æt. 54, who gave a history of having had recurring attacks of appendicitis covering a period of ten years. About six weeks previously the patient and her physician stated that she had had a more severe attack than on any of the other occasions, the abdominal pain being greater and the constitutional symptoms more marked than formerly. Since that time the patient had been unable to take nourishment, even in a liquid form, without suffering pain in the right iliac region, accompanied by severe and persistent nausea. Consequently she had accustomed herself to abstain from taking nourishment in any form for as long a period of time as possible. She was emaciated, was suffering from marked mental depression, her gums and tongue were much swollen and red, and there were various ecchymotic spots all over her body. At this time, her pulse-rate was 74 and her bodily temperature 99.4 F. On bimanual examination a tumour attached to the uterus and broad ligament, and extending up into the right inguinal region, was found. Operation was advised, and as soon as the necessary arrangements could be made, with the assistance of Dr. Rodger, of Woodbury, and Dr. A. A. Crane, of Waterbury, laparotomy was performed.

The incision was made over the right rectus muscle, the fibres of which were separated and the peritoneal cavity entered. The tumour proved to be contained in the cæcum and appendix. The adhesions which bound this portion of the gut to the uterus and broad ligament and parietal peritoneum were carefully broken up and the portion of the intestine containing the tumour was brought outside the abdominal cavity, which was shut off by gauze pads. There were no enlarged mesenteric glands, but fearing a possibility of malignant disease it was thought best to divide the bowel on either side, same distance from the tumour. The mesenteric attachment was clamped off before the vessels were divided, after which the clamp was replaced by the operator's fingers, and the vessels were caught by means of forceps and ligated with little loss of blood, probably not over 1½ ozs. being lost in the entire operation, including the abdominal incision. After the tumour had been removed the

cut edges of the bowel were washed with a small quantity of a solution of hydrogen dioxid—12½ vol.—and the cut edge of the ileum was united to that of the descending colon by means of stitches passed from within the bowel through all the coats, and through the bowel of the opposite side from without in, the knots being tied on the inside of the bowel, and thus bringing together broad surfaces of the peritoneum. The stitch used was the one whose utility was demonstrated by Maunsell. These stitches were placed about ½ of an inch apart, and carried all the way around, attaching the entire cut edge of the ileum to the colon. The calibre of the colon being greater than that of the ileum, a slit was left which was nearly closed by means of the same sutures as those which had been employed to unite the colon to the ileum, but finally a few Lembert sutures were employed to close what remained of the opening. A few Lemberts were also placed at different points over the line of union of the colon with the ileum, to insure the contact of the peritoneal coats at all points. The suture material used to unite the bowel was horse hair, and a No. 5 milliner's needle was employed. Before the bowel was returned to the peritoneal cavity the line of union was washed with a solution of hydrogen dioxid—12½ vols.—and then the abdominal cavity was washed out and filled with saline solution, and the wound in the abdominal wall was closed by means of sutures placed in layers.

The patient was returned to her bed in good condition at 5 p.m., and at 6.25 p.m. her pulse-rate was 72 and bodily temperature 99.7 F. Following the operation no morphia was given, as the patient was free from pain. She slept more or less during the night, and at 6 a.m., having no nausea, 3 ozs. of milk and lime-water were given, and this was repeated an hour later. At 7 a.m. she was catheterised and a large amount of urine drawn off. On account of her bad general condition it was found that an enema of one pint of saline solution had to be given twice daily. Her bowels moved 27 hours after the operation, and the convalescence as far as the abdominal operation was concerned was uneventful, with the exception of a stitch abscess, but was prolonged and complicated by the bad general constitutional condition from which the patient was suffering, which was prior to operation and analogous to scurvy, as was demonstrated by the occurrence of a bloody vaginal discharge which began on the second day following the operation and continued for some time, and by the patient also having trouble with salivary glands, lungs, &c. Large quantities of foul fecal matter were passed by the patient during the convalescence, which from its decomposed odour must have been retained in the intestines for a long period of time.

In a letter dated March 14th, Dr. Rodger informed me that the patient was looking well, eating and digesting her food satisfactorily, that her mouth and tongue had resumed their normal condition, and that she was up and about.

The tumour, which completely occluded the bowel, was referred to Prof. E. K. Dunham, of the New York University, Bellevue Hospital Medical College, for pathological examination, and his report was as follows: "Sections of the specimen you brought here to-day show a chronic inflammatory process, but I can find no evidence of malignant growths. The muscular tissue of the intestine is infiltrated with round cells—and the portions of the specimen which do not contain smooth muscular tissue are composed of a dense fibrous (cicatricial) tissue which is also the seat of focal round-cell infiltration. In many places the vessels show chronic endarteritis partially obliterating the lumina. A small lymph node included in one of the sections gives evidence of chronic inflammation, but there is no indication of invasion with cells from a neoplasm."

(a) Read before the New York County Medical Association.

The chief points of interest in the case are: 1, the history of recurring attacks of appendicitis covering a long period of time, ten years; 2, the general condition of the patient, which indicated great bodily depression analogous to scurvy, due to the lack of proper nourishment, and to the retention for a long time of a large quantity of fecal matter; 3, the method of suture employed; 4, the small amount of blood lost by the patient during the operation; 5, the early and constant use of enemas to improve the general condition of the patient; the early administration of nourishment to the patient in considerable quantity; 7, the character of the tumour.

PREGNANCY COMPLICATED BY UTERINE MYOMATA AND OVARIAN CYST, WITH A NOTE ON WATSON'S METHOD OF SUB-PERITONEAL HYSTERECTOMY. (a)

By RALPH WORRALL, M.D., M.Ch.,

Surgeon to the Department for Women at the Sydney Hospital.

THE following case presents features of more than usual interest, making it, I think, worthy of discussion at a meeting of the Gynæcological Society.

Edith McG., æt. 35, married two-and-a-half years, no child, no miscarriage.

Symptoms.—Noticed lumps in the abdomen shortly after marriage, these have increased in size and there has been considerable abdominal pain on exertion. Ten days ago (August 28th) was seized with very severe pain in the lower abdomen, which lasted several hours. Menses regular and profuse up to May 18th, since which the flow has been absent.

Physical signs.—Thin, pulse weak; an irregular growth occupies abdomen and reaches two inches above umbilicus. It is very hard and nodular in parts, but to left of centre feels cystic. Per vaginam, the inlet of pelvis is blocked by the hard fixed base of tumour which can be in no degree pushed up. The cervix lies high up to the left and is flush with the tumour. In the right kidney pouch there is a cyst size of a large orange, somewhat movable, not tender; the colon is distinctly in front of this cyst, which was consequently taken to be a hydronephrosis, the diagnosis of the other tumour being "pregnancy complicated by myoma blocking pelvis and rendering delivery at term *per vias naturales* impossible."

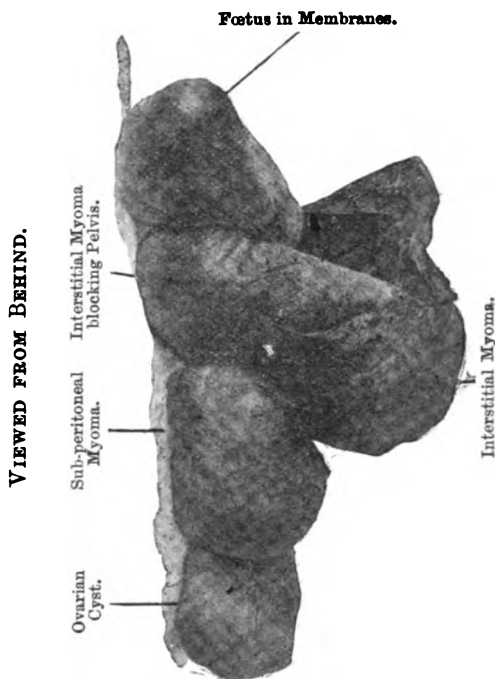
Operation on Sept. 7th, 1899.—The cyst in right loin proved to be ovarian lying behind and outside of colon, thus simulating renal cyst. The tumour consisted of the uterus gravid about the fourth month, and the seat of a multinodular myoma, with extensive subperitoneal development anteriorly and laterally. No shock. Recovery easy. Highest temperature, 100°2'. Highest pulse rate, 100.

The method of operation adopted in this case was that elaborated by Professor Watson, of Adelaide. I learnt it from him in January, 1899, and since have had a series of eleven consecutive recoveries; most of the cases were difficult by reason of subserous development, indeed, three were what Lawson Tait called "terrible cases," that is where the broad ligaments are obliterated, and the growth being chiefly cervical fills the true pelvis, and is in close contact with ureters and blood vessels.

Dealt with by antiquated methods such tumours are indeed "terrible," but by the procedure which I am about to describe they can be removed almost as easily as if they were pear-shaped tumours.

The tumour is delivered if this can be done easily,

but no time is wasted in the attempt, nor in trying to separate adhesions at this stage. In all cases one, and in most cases both round ligaments are accessible, these are immediately double clipped and divided about an inch from the uterus; the proximal clips are replaced by ligatures, and the ligaments pushed down, thus opening up two rhomboid spaces in the mesometrium. The tumour at once becomes more movable. The serosa between these two spaces is incised, and the bladder allowed to go down. The serosa between one divided round ligament and the infundibulo-pelvic fold on the easiest side is incised, opening up this broad ligament, and exposing the large vessels lying on the post blade. These are gathered up in a bunch, double clipped and divided; a silk ligature replaces the clip on the proximal side. The post blade of the broad ligament is divided towards the uterus. The uterine vessels are now clipped, cut and tied on the same side. The manœuvres are repeated on the opposite side (one ovary being left in all cases if possible) and the cervix divided, or the cervix is cut across and the



vessels on the opposite side secured from below up à la Howard Kelly. A gauze drain wrung out of a biniodide solution and powdered with iodoform is passed through the cervix into vagina and the cut edges of cervix sutured with kangaroo tendon over the gauze. The peritoneum is then united by a continuous catgut suture from pelvic wall to pelvic wall and the parietal wound closed. In securing the uterines in difficult cases it is essential to pull the uterus up and to the opposite side away from the ureter. To accomplish this, nothing is so good as a sailmaker's hook, which being conical, and thus acting as a plug, can be boldly dug into the tumour and great traction exerted.

I would strongly urge my brother gynæcologists to read Professor Watson's original papers in the *Australasian Medical Gazette* of September 20th, 1899, and in the Transactions of the Intercolonial Medical Congress, 1899. His methods for operating on myomata and carcinomata of the uterus are based upon a profound knowledge of the surgical anatomy of the pelvis, and, in my opinion, we have reached in them finality. However enormous are the vessels which course over the tumour "they are all come home

(a) Read before the British Gynæcological Society, April 19th, 1900.

to roost," that is, secure the four cardinal points, and they dwindle to insignificance. No vessel is secured *en masse* within its peritoneal envelope, all are exposed first and then tied, and in consequence there is no liability to slipping of ligatures and no mushroom pedicle to contract adhesions to bowel. No pedicle needle is used, but the vessels are clipped first and then tied, and thus there is no liability to wounding veins and the disastrous results that arise therefrom.

The other great point of difference between this method and that of Howard Kelly is that the latter says "deliver the tumour and secure the infundibulopelvic fold," while Professor Watson says "Do not deliver the tumour unless it can be done easily but let go your round ligaments as a first step and the subsequent proceedings will be immensely facilitated." If there are adhesions the tumour can be rolled off them after it has been cut away.

THE PARASITIC THEORY OF CANCER AS A BASIS FOR TREATMENT. (a)

By J. INGLIS PARSONS, M.D., M.R.C.P.,

Physician Chelsea Hospital for Women.

THE fact that the mortality from cancer for three years in England and Wales from 1894 to 1896 amounted to 67,888 (Registrar's returns) is sufficient excuse, if any were needed, for bringing these views before the Society.

It is not possible within the limits of this paper to describe all the admirable and painstaking work of various investigators on the parasitic origin of cancer. I wish only to point out that San Felice has recently been able to find and grow a micro-organism from cancer corresponding to Russell's fuchsin bodies in the older portions of the growth, and also to produce tumours of adenocarcinoma in the lower animals by direct infection. His work has received some confirmation by Dr. Plimmer in London and by others. The tumours so produced present a strong resemblance to cancer in the human body. San Felice does not, however, agree with previous observers in thinking this parasite is a protozoa, but considers it to belong to a group of fungi known by name as the saccharomycetes. This is a point of the very greatest interest. Perhaps no group of micro-organisms has received so much attention or been so thoroughly investigated in the last forty years as this, on account of their great importance in the formation of alcohol. I decided, therefore, to see how far these independent investigations of the saccharomycetes in fermentation would help to confirm or repudiate San Felice's conclusion that cancer is caused by one of these fungi.

What are the conditions of life necessary for the growth and propagation of the saccharomycetes? Are they such as to allow them to exist and multiply in the human body?

The answer to the first question is found in the works of Pasteur, Schützenberger and others.

What temperature is most suitable? Vital manifestations cease below 49° Fahr., or above 140° Fahr., while the most favourable range is between 77° and 95° Fahr. We thus see that the normal temperature of the body is only removed by very little from the most favourable temperature required.

Respiration.—Pasteur has demonstrated in the most conclusive way that these fungi absorb oxygen in water and give out a corresponding quantity of CO₂. This can take place either in the dark or in the light, and it increases as the temperature rises, reaching its maximum at 95° Fahr. When fermentation is going on Pasteur found by numerous experiments that free oxygen is formed in the decomposition of sugar. A much more important and interesting experiment showed that when fresh yeast was diffused in arterial

blood it absorbed the oxygen and turned the blood blue. Schützenberger went a step further and passed arterial blood through a system of hollow tubes of gold-beaters' skin immersed in a mixture of yeast diffused in fresh serum at 95° F. The oxygen was absorbed by the yeast and the blood lost its red colour. A control experiment done under the same conditions showed no change in colour.

We may conclude from these experiments that the fungi would have no difficulty in obtaining a plentiful supply of oxygen in the human body through the thin walls of the capillaries. I notice that Dr. Plimmer, in his paper, thought that the parasites lived under anaerobic conditions in the human body. This appears to be very doubtful.

Food, &c.—The chief food of the saccharomycetes is sugar, and Pasteur has demonstrated that a part of the sugar during fermentation is fixed in the fungi in the form of cellulose. As, however, these bodies contain proteids they also require in food something containing nitrogen. If some tartrate of ammonia is added to a pure solution of sugar and water, growth goes on more quickly. Other bodies answer the same purpose, and what is more interesting to us is that peptones and in a less degree urea and uric acid will also furnish the necessary nitrogen. Various salts, of which potassium phosphate is the most important, are also required. Finally, it has been found that the serum of blood with some sugar added to it forms one of the best mediums for the growth of these fungi, and contains everything necessary for their propagation.

Water or some degree of moisture is necessary for propagation. This power is lost when yeast is dried. If the drying process is done with care, it may recover on being moistened.

Multiplication can occur in two ways. Under favourable conditions, with plenty of food, budding takes place, and a complete fungus is given off from the parent cell, but with several varieties, whenever a deprivation of food occurs, particularly of sugar, the budding ceases, and a formation of spores takes place in the course of 15 or 16 days. Rees was the first to observe this (*Botanische Zeitung*, 1869), and Hansen has more recently developed this question and given an account of the evolution of various spores. His observations tally with those of Rees as to the conditions necessary for sporing, but he also thinks that a few fungi form spores instead of budding even when food is plentiful.

It is worth observing that in making these experiments to produce spores, the fungi deprived of sugar are very apt to putrefy, although given the advantages of moisture, warmth, and plenty of air. Knowing as we do now that the ill-effects of most micro-organisms are produced by the toxins which they secrete, it is most important to know if these saccharomycetes form anything of this kind.

Apparently they do not. The excrementitious products are principally alcohol, CO₂, glycérine, succinic acid, leucine tyrosine, and butalamine, and a small amount of fat. Many of the products are harmless to the human body, and are, in fact, also produced by its own metabolism.

A little consideration of the foregoing experiments show in an unmistakable way that the human body can furnish everything necessary for the growth of these fungi.

The temperature of the body is quite near the most favourable limit for growth.

Blood serum supplies everything required in the way of food. The physiologists have shown us that there is always a small quantity of sugar in circulation amounting on the average in healthy persons to 12 per cent.

Oxygen can be taken from the capillaries which ramify everywhere.

A sufficiency of moisture is furnished by the large quantity of water in the body. As we have seen, light appears to be unnecessary, its absence, therefore, in most parts of the body does not interfere with growth.

Further than this, if we accept these fungi as the cause of cancer we can explain many hitherto obscure points in the clinical history of this disease.

The saccharomycetes being entirely different to the

(a) Read before the British Gynaecological Society, April 19th, 1900.

various bacteria causing other diseases and apparently forming no toxin, explains the absence of inflammatory reaction and temperature in cancer, and other differences to the group of diseases caused by bacteria.

We can also understand why the disease is more rapid in the stout florid person than in the thin dyspeptic subject. The former usually has more sugar than normal in the circulation, while the latter has not. This extra amount of food in the shape of sugar for the fungi, enables them to multiply more quickly.

Cancer of the liver is more rapid than any other form and runs its course usually in from three to 12 months. This organ is the great storehouse for the sugar formed by digestion which is kept in the form of glycogen ready for use in the body. No wonder then that the disease is rapid when the parasites find their chief food in abundance around them.

Cancer of the breast and the uterus in thin old women is very often slow in its growth. In these cases the local circulation has diminished since the menopause, consequently the necessary food, &c., for the parasites brought by the blood vessels is very much less than in the case of women before the menopause. The progress of the disease is therefore slower.

Clinically, I suppose we have all noticed the remarkable difference between one patient and another in the period of time which elapses before a recurrence occurs in the glands connected with the original growth. In one patient three months may give decided symptoms of a new tumour, while in another there may be three or four or more years. I have already described how the propagation of these fungi can take place in two ways, (1) by budding when a fully-organised fungus is given off from the parent cell, (2) by the formation of spores which have to undergo development before attaining their full powers.

When a growth recurs rapidly probably the infection has taken place from fungi produced by budding.

While apparent immunity for years followed by local recurrence could be explained by the presence of spores which had remained quiescent like seeds until the conditions suitable for germination had arrived.

As we know that cancer may attack any part of the external surface of the body, also any part of the internal surface, including the gastro-intestinal, genital, and respiratory tracts, we should expect (if the cause is a micro organism) that it would be diffused in the air so that it might come in contact with the external surface, or fall on to food or be carried down to the larynx during respiration.

The saccharomycetes fulfil these conditions. Pasteur has shown that they float about in the air and are more prevalent from June to September in the temperate regions. They are found in large numbers adhering to the external surface of grapes and fruit as ripening approaches.

The advantage of moisture to these organisms will serve to explain the greater prevalence of cancer along the course of rivers and water-sheds.

Taking all these factors into consideration it seems very probable that cancer is produced by a micro-organism, and that organism belongs to the group of fungi known as the saccharomycetes.

Beyond a further corroboration of San Felice's experiments, it is doubtful whether the bacteriologist can bring any further evidence. Adeno-carcinoma has been produced on animals by inoculation, and as it is not allowable to test this on human beings it only remains to take up the question as it now stands and bring it into the domain of practical medicine.

Passing on to the question of treatment, we must, in view of the continued yearly mortality of over 20,000 for England and Wales, acknowledge that our present system of attacking the disease from the outside whether by excision or caustics or electricity cannot be considered satisfactory.

We no doubt do good, prolong life, and sometimes save it, but in spite of all our efforts there are the 20,000 deaths yearly, an eloquent testimony to our failures.

Personally, I have not the least intention of accepting our present methods as final, but will continue the fight against this disease as long as I live.

The time has now arrived when we should attempt in a systematic manner, and in co-operation, to attack the disease through the medium of the circulation.

We have before us for encouragement the example of the use of mercury in syphilis. Again in malaria we see the effect of a drug in destroying a micro-organism inimical to the human body.

We also may be encouraged by the magnificent work done to combat diphtheria by an antitoxin, although the probability of neutralising cancer in a similar way is not possible, we may find a toxin to destroy it. Coley's work in this direction is full of encouragement in the treatment of sarcoma.

In the experiment already described for the production of spores by the absence of food, I stated that putrefaction or death of the fungi was very likely to take place.

Can we starve them in the human body? We know that in stout persons who pass a little sugar in the urine, that a careful diet will at once get rid of it; but, unfortunately, the physiologists also tell us that a purely proteid diet will not stop the production of sugar in the human body. But it undoubtedly reduces it in the urine of diabetics and stout people. We may therefore expect that the quantity of sugar is also reduced even in healthy persons by appropriate diet. At any rate, it is worth trying if there is the least probability of doing good. The proportion of sugar in the blood is given by Schafer as 0.12 per cent. If we compare this with the quantity found in saccharine solutions prepared for fermentation, the difference is very great, and would account for the slow propagation in the human body with its $\frac{1}{10}$ per cent. of sugar as compared with the rapid growth during fermentation in fluids containing 5 to 10 per cent. of saccharine matter, or 50 to 100 times more sugar than is found in the circulation.

Schutzenberger described the experiments made by Dumas with various salts on saccharomycetes. I need only mention those which succeeded in arresting fermentation. They are potassium acetate, sodium sulphide, &c.

In connection with the first, it is interesting to remember that Sir Wm. Broadbent many years ago advocated the injection of acetic acid into malignant growths.

Sodium sulphide owes its activity more to the sulphur than to the soda. Therefore I determined to try the effect of calcium sulphide, as this salt has already been used and spoken well of by Dr. Ringer in the treatment of boils and scrofula, but it has not answered my expectations. In commencing the treatment of a disease for the first time with a new drug, we must remember that success may depend entirely upon the method in which it is given, also on the purity of the drug. For instance in syphilis and malaria we have two examples of disease treated by opposite methods. For the former we give repeated small doses over a long period of time, while for the latter, single large doses repeated occasionally for a much shorter time are more efficacious. It has taken us something like a century to arrive at the best method of giving a drug for each of these diseases.

Cancer has some analogy to syphilis in that it makes slow progress at first, and also exhibits long periods of latency after the primary disease has been disposed of. I therefore decided to try calcium sulphide in repeated small doses. It did not stop the growth, probably because it was decomposed in the stomach. On making further inquiry I found that salicylate of soda would stop fermentation more readily than anything else. I am now giving this a fair trial. We know that this drug is absorbed and appears in the different secretions as salicylic or salicyluric acid, it ought, therefore, to kill the parasite if it is a saccharomycete.

The observations of Mr. Bruhat and Dr. Backer open up another avenue by which we may attack the disease. Not knowing that cancer was possibly caused by a yeast, Dr. Backer suggested that a solution of the saccharomycetes should be injected so as to eat up the protozoa which was then thought to be the cause. This suggestion was the outcome of an observation by Dr. Bruhat that the saccharomycetes attacked and devoured the

bacillus aceti. Further observations showed that the young cells of yeast also attacked several kinds of bacteria.

In view of our present knowledge these experiments suggest to my mind the exact opposite of what Dr. Backer suggested. Instead of injecting the yeast, I would inject a bacterium, or rather its toxin. The very fact that the yeast attacks several bacteria shows that the latter are hostile to them and do them harm.

We can in this way explain the improvement which been noticed in cases of cancer accidentally attacked by erysipelas.

Dr. Reynolds Green has recently pointed out the partnership between yeast and some bacteria in the production of fermentation, by which both organisms profit. This association, known by the name of symbiosis, is characterised by the formation of a large quantity of gelatinous material. We may possibly find some day that the colloid cancer is formed in this manner.

It shows us that some bacteria are more inimical than others to yeasts, and we have to determine by experiments if we can which variety is most harmful to the yeasts, and least damaging to the human body.

We have for a long time known that phagocytosis does not occur with cancer. Although there are plenty of leucocytes in the tissues surrounding a growth, they do not for some reason attack the morbid cells, as we see in other diseases. There must be a reason for this, and I have suggested the absence of a toxin from the yeast parasite would afford an adequate explanation.

May there not be some means of bringing phagocytosis about.

In all probability the good effects observed after the injection of methylene blue, chelidonium majus, alcohol and other fluids are due to the inflammatory reaction which follows, and a local aggressive action on the part of the leucocytes.

As I have said before, we shall never reduce the mortality from this disease by any local treatment. We should, therefore, aim at producing general phagocytosis so as to destroy every vestige of the disease, in whatever hidden corner it may be lying in wait.

Above all we must not be discouraged by failure, nor even by hostile criticism from members of our own profession.

In respect to this disease our mental vision appears to have been obscured by the knife. In spite of the universal use of excision, and the continued multiplication and elaboration of operations, the mortality continues to increase, and now amounts to more than 20,000 a year England and Wales alone. Is it not time for us to give up this one-sided view and consider what can be done in other directions?

Transactions of Societies.

OBSTETRICAL SOCIETY OF LONDON.

MEETING HELD WEDNESDAY, MAY 2ND, 1900.

MR. ALBAN DORAN, F.R.C.S., President, in the Chair.

SPECIMENS.

DR. WALTER TATE showed (1) A large cervical myoma, the enucleation of which was followed by vaginal hysterectomy; (2) an ovarian tumour obstructing labour. Remarks in discussion were made by Drs. Heywood Smith, Herbert Spencer, A. L. Galabin, Butler-Smythe, and Thomas Wilson.

DR. HUBERT ROBERTS showed (1) A specimen of cancer of the cervix associated with a growth of doubtful nature in the body of the uterus; (2) Myxoma of the chorion. Microscopic sections of both specimens were shown. The specimens were discussed by the President, and Drs. Amand Routh, Spencer, and Peter Horrocks.

DR. A. L. GALABIN showed a specimen of very large double pyosalpinx, with a communication between the two tubes.

MULTIPLE FIBROIDS WITH DOUBLE TUBERCULOUS PYOSALPINX.

DR. PETER HORROCKS showed a specimen of this

description which he had removed from a single patient three months after the menopause. The operation was a long and difficult one, occupying 2½ hours.

THE PRESIDENT said that the association of pyosalpinx with uterine myoma was a most important question. The relationship of the two conditions was not always a causal one, but in a certain proportion of cases the sequence of events appeared to be that a hydrosalpinx was first formed as the result of pressure of the uterine growth, and infection later on led to the conversion of the hydrosalpinx into a pyosalpinx. Cases of this kind had been observed by some of his colleagues at the Samaritan Hospital, and some had also come under his own notice.

DR. CULLINGWORTH mentioned a case which had come under his care, which seemed to disprove the President's view of the etiology of the pyosalpinx. It was the case of a patient in whom he found, on operation, two very large tuberculous pus tubes. The uterine surface was studded with small fibroid nodules, so apparently unimportant that he simply noted the fact of their presence, but did not interfere with them. Some time after the operation he saw the patient again, and then found that the myomata had grown to a considerable size. Viewed in the light of after events, her condition would no doubt have been better if he had removed the ovaries as well as the tubes at the time of the operation.

DR. HORROCKS, in reply, said that it seemed to him quite possible for the pyosalpinx in these cases to arise from kinking of the tube and occlusion of the ostium tube, with subsequent infection. But this view would be negatived if the disease in the tube turned out to be tuberculous. Mr. Targett was going to examine them to ascertain this point.

IMPERFORATE RECTUM WITH PROLAPSE OF THE UTERUS IN A CHILD, ET. ONE DAY.

DR. ANDREWS showed a specimen of this unusual condition. The anus was patent, but the rectum imperforate, the septum corresponding to the tissue between the hind gut and the anal involution, found at an early stage of development. Inguinal colotomy was performed, and it was found that the prolapse of the uterus could then be reduced. The child lingered on till the 12th day and then died. The case illustrated the formation of the perineal body, which, judging from this specimen, would appear to be formed by lateral growth at each side of the lower extremity of the cloaca rather than by a down-growth from the rectum.

Remarks on the specimen were made by the President and Drs. Blacker and Arthur Giles.

THE RELATIONS OF ORGANIC AFFECTIONS OF THE HEART TO FIBRO-MYOMA OF THE UTERUS.

DR. THOMAS WILSON, Birmingham, read a paper on this subject, in which he called attention to the necessity for attempting to arrive at a just estimate of the natural history and dangers of fibro-myomata of the uterus, and remarked that in every case that came under notice it was important to look out for the possible evil effects on the other organs of the body that might have been caused by the growth of the uterine tumour. The symptoms and signs of serious organic affection of the heart were not unfrequently found in association with the presence of a uterine fibroid, and the conjunction was sometimes casual, the tumour of the womb growing in a patient already the subject of heart disease. In an appendix to the paper short notes of three cases belonging to this class were given, and it was pointed out that the heart symptoms might be greatly aggravated. In a much larger number of cases the connection between the diseases of the two organs was causal, the heart affection being set up by the growth of the fibroid, or both being dependent on a common cause. Occasionally the heart might be affected directly by the pressure of a very large cystic fibroid, or indirectly by a tumour pressing on the ureters and so leading to renal degeneration, which in its turn led to cardiac changes. Much more commonly a fibroid of moderate size led through menorrhagia to anæmia, and thus to cardiac dilatation or degeneration; or, again, in the early stages of the growth of a tumour cardiac hypertrophy might be found, and this latter

might give place to dilatation and degeneration. It was not at present understood how the hypertrophy was brought about, but the condition was in some degree analogous to the enlargement of the heart found in pregnant women; there was the important difference, however, that the causing affection, pregnancy, in the latter case was definite in duration, whereas the period of active growth of a fibroid was indefinite. The history was described in detail of a patient who had symptoms of an interstitial fibroid for four and a half years; there had been several attacks of retention of urine, and the symptoms of cardiac weakness were decidedly increased by ergot. Double oöphorectomy was performed, and was followed by alarming heart failure lasting several days. The patient made eventually a good recovery, and the condition of the heart showed a gradual but very marked improvement. Six other cases which occurred in the author's practice, and in which organic disease of the heart was apparently caused by the growth of fibroids, were shortly related in the appendix to the paper. The nature of the cardiac affection, the varieties of uterine fibroids which were present in the cases, the cardiac symptoms and signs, and the course and prognosis were then in turn considered, and it was pointed out that after a successful operation the heart tended to recover its tone in a really remarkable degree. The author further pointed out that the presence of the cardiac disease favoured the occurrence of thrombosis both before and after operation; it formed a contra-indication to the use of ergot in the treatment of the fibroid, and it might be an important and even urgent indication for operative interference. When an operation was undertaken every effort required to be made to reduce as far as possible the severity of shock and the risk of subsequent heart failure. Ether was usually the best anæsthetic, and the free use of strychnia hypodermics and saline subcutaneous infusions, or even venous transfusion, might be required. The risk of sepsis was distinctly greater than usual, and early stimulation and feeding were of the utmost importance. Six of the seven cases related recovered from the various operations which were undertaken; the seventh, after going on well died suddenly and unexpectedly on the tenth day from perforation of a latent duodenal ulcer. Of the other six cases four were examined after a sufficient interval had elapsed after the operation, and in every one of the four there were distinct evidences of improvement in the condition of the heart.

The President, in thanking Dr. Wilson for his paper, remarked that there was no subject more important at the present time, or more unsettled, than the treatment of myoma. It was necessary to steer between undue timidity on the one hand, and the *furore operativus* on the other. The opinion of many eminent surgeons at home and abroad was in favour of operative treatment in most cases; but on the other side was the attitude represented by a man much esteemed in the whole of the north of England, the late Dr. Wallace, of Liverpool, who practically gave up operating for myoma. He had himself noted the association of myoma with cardiac conditions. Thus, in one case, the patient had a myoma weighing about 6 lbs.; there was no menorrhagia, but the patient had two attacks of syncope. He removed the uterus and ovaries, and since then there had been no attacks of syncope. He had heard a hæmic murmur in a case where there was no anæmia, but where the tumour was a fair size. In another case there was considerable irregularity of the pulse, which disappeared after operation.

Dr. AMAND ROUTH referred to Dr. Wilson's observations on the increase in symptoms of cardiac weakness produced by ergot. He saw a patient, æt. 40, with an impacted fibroid in the pouch of Douglas. He raised the fibroid and sent the patient home. She had apparently looked up works on the subject, and concluded that fibroids and ergot went together; so she started taking the latter, with the concurrence of her medical man. She gradually lost strength and got very ill, with tachycardia and weakness of the heart. Sir William Broadbent, whom she consulted, attributed the symptoms to ergot; she stopped the drug and got quite well.

Dr. HERBERT SPENCER, commenting on the weakness of the heart due to loss of blood in cases of fibroid, said that one of the worst cases of anæmia he had seen was in a patient who had a tumour reaching up to the umbilicus. He removed the ovaries on the day following that on which he saw her. She had twice nearly died from syncope; but so rapidly did she recover that three or four weeks after the operation she was quite blooming, and her friends hardly recognised her. He believed that as a rule the ovaries should be left behind when removing a uterine myoma; but it was quite possible for a patient to enjoy perfect health after the ovaries had been removed.

Dr. BLACKER thought that six or seven cases of cardiac disease associated with myoma were not sufficient to establish a causal relation between the two conditions. He would like to ask Dr. Wilson how many cases of myoma he had observed from this point of view; and also why he considered that cardiac hypertrophy was an indication for operation?

Dr. WILSON, in reply to Dr. Blacker, said that when there was hypertrophy there was a risk of consequent dilatation and degeneration, and it was to prevent such a result that operation should be done. His observations were made on about 200 cases of myoma altogether; but he did not advocate operation in every case, reserving this treatment for cases in which there were special indications. Dr. Spencer had dwelt on the influence of loss of blood on diseased conditions of the heart; he quite recognised this sequence himself; but in four of his cases the cardiac disorder did not follow anæmia, but was the direct result of hypertrophy due to the presence of the tumour. He was much surprised to see the view expressed lately in a medical journal that the deaths due directly to myoma were represented by a very small fraction; he was sure that patients really did die of fibroid tumours unless operated upon.

BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD THURSDAY, APRIL 19TH, 1900.

The President, Dr. W. J. SMYLY, in the Chair.

SPECIMENS.

The Secretary read a paper by Dr. RALPH WORRELL, of Sydney, N.S.W., on "Pregnancy complicated by Uterine Myoma and Ovarian Cyst," which will be found on page 471.

Dr. J. INGLIS PARSONS read a paper on "The Parasitic Theory of Cancer as a Basis for Treatment." This paper will be found on page 472.

Dr. HERBERT SNOW said that on analysing the scientific and practical points in Dr. Inglis Parsons' paper, they appeared to him to be of a very reversionary order. The reason that the surgical treatment of cancer was unsatisfactory was that operations were often incomplete or performed too late. Many attempts had been made to identify and isolate the germ of cancer, but without success, and until this was done such a paper as they had heard struck him as rather premature. The most rabid bacteriologist must admit that between the phenomena of cancer and those of every other disease due to micro-organisms there was a great gulf fixed. It was difficult to him to suppose that any parasite could produce such phenomena as were found in the secondary deposits of cancer; for instance, the exact mimicry of the structure of the mammary gland in the case of growths in the liver, or the mimicry in the lung of the structure of the columnar cells of the rectum. The paper did not seem to him a practical one.

Mr. CHARLES RYALL congratulated Dr. Inglis Parsons on his courage in bringing forward this paper on a very controversial subject. There was not enough known to enable them to assign the germ of cancer to the group of blasto-mycetes. The latter would grow in certain media, but cancer-bodies would not. Mr. Plimmer, after many experiments, had succeeded in getting the cancer-bodies to grow; and on injecting the culture into the peritoneal cavity of animals, he got a new growth; but it was not of the same character as the tumour from

which the culture was obtained, for it was an endothelial, not an epithelial growth. Mr. Plimmer, had, however, told him that he had lately succeeded in producing an epithelial growth in the skin. But results were not at present such as to offer any hope of treatment based on the parasitic theory.

Mr. BOWENMAN JESSETT said that in his opinion cancer was a local disease, and as such should be treated from the outside, surgically, and not from the inside by medicines. There was, no doubt, something in the hereditary theory of cancer; he made some investigations on this point some years ago, and met with some striking instances of cancer occurring in several members of the same family. He felt sure that if cancer could be seen early enough it could be cured; the most favourable cases were those of patients at or past middle life; but the results of operations in young subjects were unfavourable. Repeated operations were sometimes necessary; but in some cases a cure could be hoped for in the end.

Dr. MACNAUGHTON-JONES thought that in their discussions it was pleasing to sometimes get away from the knife. Although at present no definite information was forthcoming as to the etiology of cancer, he thought that it was all-important that they should discuss it at times; and so far from being, as Dr. Snow suggested, an unpractical subject, it was the very reverse. He did not take the paper to be an argument against operation in cases where this was practicable, but an attempt to deal with cases which might be inoperable.

Dr. INGLIS PARSONS could not agree with the aspersion on the medical profession made by Dr. Snow when he said that operations for cancer were badly done. On the contrary, he thought that their surgery was good, whatever might be the result of other methods of treatment. Mr. Jessett had laid down the view that cancer was a local disease as if this doctrine were new; the very essence of his paper was the assumption that cancer was a local disease; for if due to saccharomycetes, the condition must be a local one. Dr. Snow had remarked that the phenomena of cancer were different from those of other diseases caused by germs, but then the saccharomycetes were different from any other micro-organisms. He did not advocate that the knife should not be used, but he wished very much to stir up the more conservative spirits in the profession as well as others, who did nothing at all for the 20,000 cases that died annually of cancer, to induce them to try some new plan rather than sit by with folded hands on the plea that nothing could be done.

ROYAL ACADEMY OF MEDICINE IN IRELAND. SECTION OF MEDICINE.

MEETING HELD FRIDAY, APRIL 6TH, 1900.

The President, Dr. J. W. MOORE, in the Chair.

Dr. CONOLLY NORMAN showed a case of chorea, apparently associated with trauma, and complicated with melancholia.

ON THE SYMPTOMS OR PHENOMENA FORMERLY KNOWN AS "CROUP."

Dr. LANGFORD SYMES read a paper on the clinical significance of the various diseases embraced by the term "croup." He described five chief croupy symptoms: (1) Laryngeal stridor; (2) cough, with a barking, "croupy" sound; (3) night attacks; (4) restlessness; (5) recession of the chest. These are the symptoms popularly called croup. Three main species of disease must be clearly differentiated:—I. Diphtheria (of which there appear to be several varieties). II. Laryngitis; (a) "acute laryngitis;" (b) "laryngitis stridulosa." III. Laryngismus. Laryngismus, he observed, is an entirely different condition from the other two, and should not be included in the term, for it does not produce true croupy symptoms. It was mentioned for the purpose of elimination and distinction. True croup is diphtheria, and most deaths registered as croup are really diphtheria.

Dr. DEURY asked Dr. Symes in what class he would put cases of laryngitis closely resembling croup met with in measles. He saw an enormous number of such laryngitis cases in the last epidemic, and such a number of tracheotomies had to be performed that almost all the tracheotomy tubes to be obtained in Dublin had been requisitioned. At one time there were some 25 to 30 cases all with tubes in, but they were not diphtheritic cases, nor were they laryngismus stridulus, and most of them recovered.

Dr. DOYLE recommended the use of sulphate of copper in croup.

Sir GEORGE DUFFEY said he quite agreed with Dr. Doyle as to the benefit of sulphate of copper in such cases, as contrasted with depressant emetics. He believed they were often inclined not to give enough antitoxin, and he had never seen any bad effects follow its administration.

Dr. PARSONS said that from his point of view diphtheria was an inflammation produced by the Klebs-Löffler bacillus, and it did not make any difference whether the inflammation was catarrhal, croupous, or diphtheritic. Some other name would then have to be found for cases of inflammation of the throat produced by other micro-organisms. In addition to Dr. Symes' two indications for surgical interference he thought they might also add cyanosis.

The PRESIDENT agreed that the dyspnoea of diphtheria was not a night symptom, whereas that of laryngismus stridulus was essentially a night symptom. He agreed with Dr. Duffey in believing that diphtheria is often apyrexial, and if they had high fever it was probably not diphtheria. The absence of knee-jerks, however, as well as albuminuria, only appeared after toxic poisoning had taken place, and, therefore, were not trustworthy indications early in the disease.

Dr. LANGFORD SYMES, replying, said he believed there were many varieties of the disease commonly called diphtheria.

PEMPHIGUS, WITH CONCURRENT ERYTHEMA (IRIS).

Dr. H. C. DEURY described the case of a boy, *et.* 14, who was under his care in Sir Patrick Dun's Hospital suffering from a severe attack of acute pemphigus, with concurrent erythema. The erythema was the "iris" form, and was very extensive over all parts of the trunk and extremities. Many circles, becoming confluent, formed very large irregular patches. The pemphigus was also very extensive, and was found on all parts of the body, sparing the conjunctivae. The bullae varied in size from that of a hempened to large, irregular bags of fluid more than 3 inches by 2 inches. Into many of these hæmorrhage occurred. They occupied the site of the erythema, but were not so extensive. A febrile disturbance appeared early, and increased regularly till the 10th day, then gradually subsided till normal temperature was reached on the 18th day. During this period the patient was in a very critical condition, and from the position and extent of the bullæ their rupture and ulceration was inevitable, causing considerable suffering. He made a satisfactory recovery. He was given the acid solution of arsenic in gradually increased doses up to 7½ minims three times a day, with iron.

The Section then adjourned.

LIVERPOOL MEDICAL INSTITUTION.

MEETING HELD THURSDAY, APRIL 26TH, 1900.

The President, MR. EDGAR BROWNE, in the Chair.

CASES.

MR. BARK showed a man, *et.* 30, with cysts in the glosso-epiglottic fossa, the largest having a diameter of a quarter-of-an-inch, was a yellowish white globular swelling, on the right of the glosso-epiglottic frænum, and there were two others on either side of the frænum about the size of a split pea. The symptoms produced are excessive secretion of saliva, with a constant desire to swallow, which produces a sensation of a lump at the back of the tongue. Mr. Bark proposes to remove them by means of laryngeal punch forceps.

Mr. F. C. LARKIN read notes of a case of "Fracture involving the Interior Fossa of the Skull, with Nasal Hydrorrhœa." A young man, *æt.* 20, met with a cycle accident which rendered him unconscious for three or four hours. This was followed by a profuse discharge of fluid from the nose, the character of which was cerebro-spinal, and the flow lasted about six weeks. He was only off work altogether for a few days, and complained only of headache and of being bothered by the fluid coming from his nose. After the discharge ceased, the headaches continued. Eight weeks later he was seized with symptoms of cerebral meningitis and died. The post-mortem showed considerable fracture of the orbital plates of the frontal and of the ethmoid, and that a wide communication existed between the cranial cavity and the nose, the track running by way of the anterior ethmoidal cells and the antrum of Highmore.

The parts implicated, with photographs and sketches were exhibited.

Dr. J. M. HUNT showed a case of Dysphonia Spastica. The patient was a hysterical male, *æt.* 50, who lost his voice suddenly six months ago without apparent cause, and since then has been either quite aphonic or has spoken in a high falsetto. On attempted phonation the cords are so strongly approximated that the right vocal process crosses over the top of the left. If the patient makes an effort to speak during the periods of aphonia, his face becomes livid, and the muscles are convulsed. The normal voice can be restored by pressing on the epigastrium, but immediately disappears on removing pressure.

Dr. NATHAN RAW showed a specimen from a patient who had suffered from acute oesophagitis for over six months. After a violent fit of choking he expelled a complete cast of the oesophagus which appears to consist of the epithelial and mucous lining of the gullet. The specimen is $8\frac{1}{2}$ inches long and in a perfect state of preservation. The man is recovering, although he still has great pain and difficulty in swallowing.

Dr. RAW also showed a man on whom he had operated for a large liver abscess. The patient had been abroad for 20 years, and six years ago had dysentery; he presented all the symptoms typical of the affection, with the exception that the exploring needle failed to find the pus. The abdomen was opened in the right Langenbeck's line, and the liver found to be adherent to the costal arch in its upper two-thirds. The abdominal wound was closed and an opening made through the 7th interspace and 32 ounces of chocolate-coloured pus withdrawn. The patient made a good recovery and is now following his employment.

Dr. JAMES BARR read a paper on "The so-called Pulsus Paradoxus." He said that he had been working more or less at the pulse for a quarter of a century, and he had never been able to find the paradox, though he was well acquainted with the condition of the pulse, which became smaller or disappeared during respiration. Since the appearance of Kussmaul's paper and erroneous interpretation of this phenomenon in 1873, an undue importance had been given to the condition which was merely an exaggeration of a perfectly normal state of the pulse. Anyone having a good respiratory pump and moderately low arterial tension, could develop the so-called pulsus paradoxus in himself, and such a one by carrying out the Valsava method could completely obliterate his pulse at the wrist for several beats. He looked upon the condition as a decided advantage to the individual both in health and disease, seeing that it is evidence of the integrity of the respiratory pump which is a great aid in carrying on the circulation.

Dr. JOHN HAY thought Dr. Barr seemed inclined to magnify the recognised effects of abnormal respiratory efforts on the normal pulse, to minimise the fact that a paradoxical pulse during normally quiet breathing might occasionally be of value in diagnosis. Normal respiration in a normal individual failed to produce that rhythmical and marked variation which was termed pulsus paradoxus. This variation, when pronounced, was in his experience always associated with some pathological condition, and what was necessary was rather to locate and give proper value to it as a physical sign.

Dr. A. G. GIELLAU thought that the fact that the

pulsus paradoxus, as shown by Dr. Barr, could be produced artificially by a simple pathological experiment in persons with low pulse tension agreed with those recorded cases where it had been noticed in children while asleep, and also with the fact that pathologically it was almost always found in pulses of low tension.

Drs. Abram, Buchanan, Grünbaum, and Lloyd-Roberts also took part in the discussion, and Dr. Barr replied.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

A MEETING HELD (IN OWENS COLLEGE, MANCHESTER),
FRIDAY, APRIL 20TH, 1900.

The President, Dr. HELLIER (Leeds), in the Chair.

Dr. HELLIER related a case of "tubal pregnancy," removed by abdominal section after rupture at the end of four months. No symptom was observed until the rupture took place. The specimen consisted of a foetus at $4\frac{1}{2}$ months' with a well-developed placenta and sac. The patient made a good recovery.

Dr. HELLIER also showed a specimen of retained menstrual fluid from a case of "imperforate hymen." The case was of interest in that the patient, a girl, *æt.* 15, with a tumour reaching three inches above the umbilicus, had absolutely no symptom of pain or pressure. Six pints of this chocolate-coloured fluid were removed, after incision of the hymen.

Dr. LLOYD ROBERTS (Manchester) showed two unusual specimens of large "fibroid polypi." Case 1.—A firm mass filled the vagina and blocked the pelvis. The patient had never complained of pain, and only slight hæmorrhage had been present. Case 2.—A tumour the size of a large fist protruded from the cavity of the uterus nine days after a natural labour at full term.

Dr. ARNOLD LEA showed a "soft fibroid" the size of a child's head removed from the vagina of a nulliparous woman, *æt.* 42. The growth had caused no symptoms until 12 hours before the operation, when severe uterine contractions resembling labour resulted in the discovery of the tumour, which was removed by morcellation.

Dr. ARTHUR HELME (Manchester) related (1) a case of "ovarian sarcoma" in a girl, *æt.* 13, and showed the specimen with microscopic sections. The tumour was removed in April, 1899. The abdomen had recently again become enlarged, and abdominal section showed that masses of soft growth were invading the omentum and the general peritoneum. (2) Dr. Helme also showed two specimens of "fibroma uteri" removed by total abdominal hysterectomy. No drainage was used. Both patients made uneventful recoveries.

Professor SINCLAIR read a short paper on the PREVENTION AND RELIEF OF PAIN IN MINOR GYNÆCOLOGY.

He referred to the necessity of reducing the pain suffered by women in the minor manipulations and operative procedures. In some cases also women were very reluctant to submit themselves to total anaesthesia. In many cases operative measures could be carried out with slight pain by the use of a judicious combination of morphia, alcohol and cocaine locally. The administration of two ounces of alcohol disguised if possible, and followed by a hypodermic injection of morphia had an excellent effect in diminishing sensitiveness. Under their influence, curetting, intra-uterine medication, Emmet's operation, and perineorrhaphy could be readily carried out. Cocaine should be used in a 10 per cent. solution locally, and in his experience it never produced any toxic symptoms.

Remarks were made by Drs. Martin, Lloyd-Roberts, Stallard, Briggs, and the President.

ON and after July 4th next the toy pistol nuisance in New York State is likely to subside, the Governor having signed a Bill which makes it a misdemeanour to sell or give a toy pistol in which blank cartridges are used to a person under sixteen years of age.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, May 6th, 1900.

MECHANISM OF SENILITY.

M. Marinesco read a paper on the above subject at the last meeting of the Académie de Médecine. The problem of the senility and the death of the different elements of the organism had, he said, up to the present, attracted but little attention from biologists. Quite recently M. Metchnikoff made an interesting study of that question. According to him, senile atrophy would be the result of intimate cellular phenomena, of a struggle between the elements of the tissues, struggle from which the conjunctive tissue came out victorious, the macrophages provoking the disappearance of the noble elements incapable of defending themselves. The means of arresting that senile degenerescence would be the destruction of the macrophages by an appropriate serum. Researches practised on a large number of preparations taken from the nervous system of persons between the ages of 80 and 110 years proved to the speaker, contrary to the opinion of M. Metchnikoff, that senile atrophy was the result of intine modifications taking place in the nerve cell. Those modifications might be resumed as follows:—(1) Rarefaction and disorganisation of the chromatophyle elements giving rise to a kind of senile chromatolysis; (2) formation in considerable quantity of an inert substance derived in a great part, as he had demonstrated some time ago, from the destruction of the chromatophyle elements and diminishing the nutritive and respiratory capacity of the cell; (3) disappearance of a certain number of prolongations of the cell; (4) more or less decrease of the cellular body and ending for certain cells in complete atrophy.

Nowhere were observed, in the nerve tissue of the aged, nerve cells devoured by phagocytes. On the other hand, in the course of different pathological conditions, especially when the achromatic substance is disorganised, the nerve cell was invaded by elements playing the rôle of neuronophages. That condition was very apparent in certain cases of myelitis in the medulla of animals, on which was practised ligature of the abdominal aorta, &c.

The reason of the senility of the nerve cell should be sought for, according to the speaker, in a fault of chemical synthesis, which produced disorganisation of the element, and became manifest by the reduction as to the volume and the number of chromatic granulations, by senile chromatolysis, by the formation of a so-called pigmentary substance, &c.

To prevent those manifestations of degenerescence, it would be necessary to stimulate the chemical synthesis of the nerve cell by the administration of a dynamogenic substance, such as the serum of young animals.

OPERATIONS IN GLOVES.

M. Quénu spoke at the Société de Chirurgie on the aseptic advantages of wearing indiarubber gloves while operating. He said that it was impossible to sterilise the hands sufficiently, and the use of gloves of caoutchouc simplified singularly the question, for without that precaution the surgeon should in general renounce all septic interventions forty-eight hours, at least, before an aseptic operation. The same precaution of protecting the hands permitted the making of auto-

sies, but, as a rule, the operator should never enter an autopsy room, as it was never properly cleaned. M. Tuffier said that for his part he would never let a surgeon operate on him who had previously done a septic operation. As regarded indiarubber gloves he recognised their advantage in performing septic operations, but he preferred thread gloves for aseptic operations. But before everything he considered that the rapidity of the operation was an essential factor in the success of the intervention. To put on the caoutchouc gloves easily it was only necessary to fill them with water.

TREATMENT OF ORCHITIS.

Dr. Pigot highly recommends the following treatment for orchitis due to gonorrhœa:—The patient is first given an ounce of salts as a purgative and then salicylate of soda, 15 grs., four times a day. Improvement shows itself after twenty-four hours, and at the end of eight or ten days, the cure is complete. Mercurial ointment need only be employed where there is effusion into the vaginal sac. During the treatment the patient remains in bed, and maintains constantly *in situ* a suspensory bandage lined with cotton wadding.

HEMORRHOIDS.

After washing the region antiseptically and applied a coating of an ointment composed of vaseline and iodoform, an injection of a full hypodermic syringe of the following solution is made:—

Chloride of zinc, grs. x;

Hydroch. of cocaine, grs. iv.;

Water, distilled, 3ss.

The day following a slight reaction takes place, but yields readily, and at the end of the fifth or sixth day the tumour has withered up.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, May 5th, 1900.

THE TWENTY-NINTH GERMAN SURGICAL CONGRESS.

THIS Congress was held in Berlin from April 18th to the 21st, under the presidency of Hr. v. Bergmann. In an introductory address in speaking of the deaths that had taken place during the past year, the President mentioned the late Sir James Paget, referring to his career as one of great brilliancy and great usefulness to science.

The first scientific address was delivered by Professor Czerny, the subject being

THE TREATMENT OF INOPERABLE CANCER.

Cancer cases not amenable to treatment when first met still amounted to about 75 per cent. of the whole. In Germany about 40,000 people died annually of cancer. It was our duty to help cancer cases, even if we could not cure them. In by far the greatest majority of cases we could only keep up their courage, by suitable means make their position bearable, and not allow their hope of recovery to fail. This ethical side of the surgeon's calling was often ignored, and through it patients were driven into the hands of quacks. With such patients the surgeon should be gentle, and the speaker himself had received them back after they had left him for quacks. He could not deny that he had not unfrequently rejoiced when a mild death had freed patients from their torments.

The reasons why so many patients turned to quacks were:—(1) the innate superstition of the people; (2) the readiness with which they changed their doctor; (3) an active interest in such cases ceased when an operation was no longer practicable. That was not right. The surgeon should foresee the bad times that would come and without destroying the patients' hope prepare them for these bad times, and by the use of many little empirical means alleviate their condition.

Only to operate when all the disease could be removed was not right. Slow growing, not ulcerated scirrhus in old women should not be operated on. Such cases had a tolerable and fairly lengthened existence. When ulceration and hæmorrhage took place operation should be performed, as by this means patients were freed from great trouble for the rest of their lives. Here gastro-enterostomy and similar operations were indicated. Among the palliative operations were ligature of the afferent vessels, curettement, cauterisation with the thermo-cantery or better still with a 60 to 80 per cent. solution of chloride of zinc. The smart pain lasting a few hours was easily relieved by morphia. In six inoperable cases of cancer of the rectum, a tampon of chloride of zinc had done a great deal of good—in one case so much that a radical operation could be carried out later on. Formalin also in 10 to 30 per cent. solution could be used as a dressing; an old remedy was arsenic in paste. Painting with an arsenical solution only acted as a caustic. Arsenic often did a great deal of good in malignant lymphoma. The newly recommended remedies, the citrate of neurine and cancrine were useless. As an antiseptic local application, iodoform was very useful. The vegetable remedies, cicista and chelidonium were improperly neglected, and success was sometimes met with from condurango bark. The various dietetic cures had no influence on the disease. Thyroid extract was useless. As regarded the influence of accidental inflammatory diseases, such as erysipelas, or erysipelas produced by the injection of streptococcus cultures, not enough was known to admit of a decided judgment.

For light as to the causes and cure of carcinoma, concentrated labour was necessary, and a necessary condition was the foundation of proper cancer hospitals such as existed in England and were more lately founded in America. Such hospitals should be entrusted to younger members of the profession who were familiar with all the advance of science. The State would be in duty bound to assist, as with a retrocession of tubercle there had been an advance in carcinomatous diseases. Town populations suffered more from cancer than country populations. Of 1,000 inhabitants of the former 9·26 suffered from cancer, whilst of the country population only 0·1 per 100 so suffered. The disease extended the more, the more thickly populations were packed together; but the suspicion could not be altogether rejected that the disease was due to a nova that underwent one of its several changes outside the human body.

Hr. Friedrich, Leipzig, was of opinion that the parasitic theory was the one of most value from a therapeutic point of view. His former chief Thiersch was inclined to the theory. The speaker placed the most importance on the microscopic differential diagnosis. In a large number of apparently malignant tumours after long observation their lactic nature was recognised. As

a useful remedy that he had seen good effects from, he recommended Kohl's antitoxinstreptococcus preparation.

Hr. Helferich had seen very good effects from tampons soaked in chloride of zinc. The reaction was very slight, the vessels died in the slough, so that no hæmorrhage took place. A peculiar phenomenon was that in microscopic examination of the slough the carcinomatous character could be recognised as completely as in a case of disease not yet submitted to treatment.

Hr. Steinthal, Stuttgart, had seen a patient remain free from disease four years after the application of zinc chloride.

Hr. Krönlein, Zurich, then gave an address on the
RESULTS OF OPERATIVE TREATMENT OF CANCER OF THE COLON AND RECTUM.

The paper was to a large extent a compilation in which the results of a large number of operators were brought together. The operators, German surgeons, eleven in number, had operated in 881 cases, Gussenbaur performing the largest number, 145, and Kocher the smallest, 35. Out of the 881 operations there were 171 deaths in connection with the operation. The causes of death were as follows:—

Sepsis	...	...	...	51·8 per cent.
Cardiac weakness and collapse	...	...	20	„
Affection of the lungs	...	...	13	„
Accidental diseases	...	...	15	„

As regarded permanent results, there was more pessimism among surgeons than the pathological anatomy warranted. Real metastases were not very common. In 70 cases dying later real metastases were only found in nine, local recurrences, on the other hand, in 47. In 640 cases operated on a permanently good result (three years immunity) followed in 14·8 per cent. There were 63 cases in which recurrence took place later after 5, 6, 8, and even 12 years. As regarded permanent results selection of the cases was of great importance, the wider the circle of indications for operation was drawn the more were the permanent results. We had no ground for widening the circle; possibly it was already too much extended. Cancer of the rectum that had already extended to neighbouring organs should not be operated on, the results were frightful. The speaker would rather have the circle of indication somewhat narrowed.

He summed up as follows:—

1. The sovereign method of operative treatment of cancer of the rectum was extirpation.
2. In four-fifths of the cases recovery might be expected.
3. In one-seventh of the cases permanent good results followed.
4. For the maintenance of continence, sparing of the lower portion of the rectum was of great importance.
5. The results of total resection were worse in every case.
6. The different methods of operation were to be carried out eclectically; the plastic method was always something to be desired.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, May 5th, 1900.

TREATMENT OF PNEUMONIA.

At the Congress of Internal Medicine, Koranyi, of Buda Pesth, read an interesting paper on the treatment

of acute inflammation of the lungs. In his preliminary remarks he suggested that the simple croupous inflammation of the lung should be distinguished from the asthenic form of inflammation.

This distinction is indicated ætiologically from streptococci pneumonia, which anatomically is cellular pneumonia. That Fraenkel's diplococcus lanceolatus and the streptococcus give different results according to intensity is an admission of two forms. He considered this diagnosis of a primary fibrinous asthenic pneumonia as important in the treatment.

Recent pathology had taught us to be careful in examining the blood in pneumonic cases before we attempt treatment with serum, as it is first necessary to know exactly the bacteria present, and the amount of toxin operating. The serum treatment had not on the whole been a success. In examining the blood, leucocytosis is often found in pneumonia, and this led to the theory of treatment with pilocarpin, antipyrin, antifebrin, nuclein, and Hydropathy, which he considered unsound. His own examination of the blood consisted in estimating the sp. g. the amount of chlorides and the freezing point of the fluid which is usually higher than in other conditions. To restore a normal state it is necessary to drive a stream of oxygen through it to relieve the chlorine saturated serum. This form of treatment is also practised by Powell, Grey, and others.

Bleeding is anti-pneumonic treatment, and need not be mentioned. There is a combination of bleeding and injecting a NaCl solution that seems reasonable where "ischæmia" on the left side of the heart is relieved; at the same time, the diuresis is increased that washes off a large quantity of the toxic agent. In the treatment of pneumonia digitalis, antipyretics, alcohol, opium, ice, and a few others of this class were very questionable. In conclusion, he thought that each case required special treatment according to the symptoms. He firmly believed in the efficacy of baths, but thought there was no specific treatment.

In the discussion Muller produced the statistics of the army for the last 20 years in Prussia, Saxony, and Wurtemberg. During the whole 20 years there were 85,000 pneumonic cases recorded or an average of 4.10. When calculated according to the strength of the army the average was 12.7 per 1,000, which at the most averages only 6.8 per 1,000.

This happy result has undoubtedly been brought about by the sanitary condition of the barracks, and a more healthy state of the recruits. The mortality of these pneumonic cases at the present time is 106 per annum, making it 15 per cent. of the total death-rate. If phthisis be excluded it will be reduced to 4 per cent. There is no particular form of treatment laid down for the army physician.

According to the case-book the average period for each soldier in hospital is four weeks. Jurgensen maintained that the hydropathic treatment was the most rational and efficacious as it supported the strength of the weak heart and relieved the temperature.

Remf strongly advocated the normal solution of sodium chloride in supporting the weak heart of pneumonia and improving the fluidity of the blood as well as encouraging diuresis. Rosenstein recommended an accurate percussion of the cardiac area, and as soon as the dullness had extended over the left and was approaching the right lung, accompanied with a frequent pulse, which was

a dangerous prognosis, right side irritants should be commenced.

Smith loudly warned against the use of alcohol, as it endangered the life of the patient by producing cardiac dilatation. Paessler condemned the use of chloral hydrate as a sedative, as it caused vascular paralysis and increased the operation of the pneumococci by their accumulation in the vessels. Schultze thought that alcohol in drunkards would often be found useful. He recommended analeptics, coffee, and camphor, but digitalis he had no faith in.

Naunyn was in favour of expectorants, particularly, potassium iodide. Ergotin was an excellent remedy against collapse as it produced a higher pressure in the vessels.

Lenhartz thought that pneumonic patients did not die of heart and nerve enfeeblement alone, but of bacteriæmia. The examination of the blood was of considerable prognostic value. Digitalis, in his mind, was the best tonic for the heart, as after 40 years of age the elasticity of the cardiac muscle was reduced.

Nothnagel recommended the hydropathic treatment, but for medicine he had no prompt remedy. Senator advised the use of alkaline mineral waters, or alkali hydrochloric, because they hastened the afflux in the bronchi.

Australia.

[FROM OUR OWN CORRESPONDENT.]

A MELBOURNE MEDICAL DISPUTE—RESIGNATION OF THE BRANCH COUNCIL OF THE BRITISH MEDICAL ASSOCIATION.

ONE of the leading Melbourne hospital surgeons, who is well known for his kindness and generosity in emptying his purse to help a fellow-practitioner in distress or to assist in other charitable efforts, has been taken advantage of by an enterprising chemist in allowing his name to be mentioned in recommending a drug. The chemist turned this recommendation to the use of forming a syndicate for the floating of an objectionable patent medicine. As soon as it was noised abroad that an eminent surgeon's name had been associated with the discreditable venture he at once took steps to have his name withdrawn, and statutory declarations were made by the chemist aforesaid and by his solicitor exonerating the surgeon from complicity with or knowledge of the transaction or of the literature connected with it.

The Council of the Victorian branch of the British Medical Association, however, determined to expel the surgeon from the Association, of which he is a member. They passed a resolution to that effect, and canvassed the general members to support the expulsion, threatening, in case of non-compliance, the breaking up of branch.

At the general meeting of members last week the merits of the case were discussed, and the President, on being asked why the evidence upon which the Council formed their verdict was not supplied to the accused after he had made three applications, replied:—"The Council was afraid to furnish the evidence, lest members should prejudice the case in favour of the accused." No wonder that Dr. Mullen, who is not only a member of the Association, but also a barrister

characterised the whole proceeding as a "star-chamber job."

When the matter was put to the vote, 34 voted against the Council and 31 for it. The 31 included three female members.

As a result of the proceedings the Council (15 members) resigned, and there is a kind of disruption of the branch. Reasonable men in and out of the profession begin to ask what is the use of such a fraternity when on the slightest pretext they jump upon each other? Such a connection is apt to degenerate into cliques and hotbeds for hatching conspiracies.

The Operating Theatres.

ROYAL FREE HOSPITAL.

CHRONIC OBSTRUCTION OF THE LARGE INTESTINE DUE TO MALIGNANT GROWTH.—COLOTOMY.—SUBSEQUENT EXCISION OF GROWTH.—MR. BATTLE operated on a man, *æt.* 43, who had been admitted suffering from chronic obstruction of the large intestine. The symptoms were the usual ones. Abdominal pain and distension, with vomiting and constipation; the symptoms were not acute. Mr. Legg, the senior resident Medical Officer, had performed colotomy in the usual situation, the bowel being opened two days later. After this operation the patient progressed satisfactorily: the artificial anus acted well, and all his symptoms subsided. As it was not known what had caused the obstruction, and Mr. Battle regarded it as most likely the result of some malignant growth of the sigmoid, he thought it desirable that an exploration through a median incision should be made, and if the diagnosis was correct the growth should be excised, did its attachments permit. A median incision was made, and a growth of carcinomatous character was found in the sigmoid flexure, about five inches from the artificial anus. It was freely movable, excepting where anchored to the site of the previous operation, and could be brought outside; there were, however, several large glands extending into the meso-sigmoid. The growth was drawn outside the abdomen and placed on gauze squares; it was then isolated above and below, two pieces of drainage tube having been passed through the mesentery and secured by means of artery forceps; there were two pieces of tubing above, and two below the tumour. The intestine was then divided between the tubing, the cut surfaces carefully cleansed and wrapt in different pieces of gauze. A V-shaped piece of the meso-sigmoid was then divided and the glands included in it with the growth removed. The two ends of the intestine were then treated one after the other, after the vessels had been secured by means of continuous Lembert's sutures; they were then placed side by side, and lateral anastomosis effected. A row of continuous Lembert's sutures was first inserted, then the necessary cuts made in the opposed surfaces of bowel, continuous whipping suture being carried round the openings thus made through all the coats. Afterwards the first continuous suture was carried round a quarter of an inch from the opening so as to complete the second row: one or two reinforcing stitches were also put in. The intestine was then cleansed, and returned to the abdomen, and the abdominal wound closed in three

layers. The growth was a cylindroma, and had almost closed the lumen of the bowel which it completely surrounded. Mr. Battle said that he considered this method of lateral anastomosis after an excision of malignant growth of the large intestine was probably the best, and he had had successes by it. In some cases, however, it might not be possible to bring out the bowel sufficiently far to permit of the necessary apposition, and the formation of an opening of sufficient size; under such circumstances an end-to-end anastomosis would be probably best, but the different size between the upper and lower ends was sometimes a cause of difficulty in that method of restoration of the intestinal tract.

KING'S COLLEGE HOSPITAL.

OPERATION FOR INTUSSUSCEPTION IN A BABY.—MR. PEYTON BEALE operated on a baby, *æt.* between 8 or 9 months, who had been admitted under the following circumstances:—At 8 in the morning on the same day the child had been seized with violent abdominal pain and refused the breast. The mother brought it to Dr. Still's out-patient department and he diagnosed intussusception, and asked Mr. Beale to see the case, which he did at 3 p.m. The conditions then were as follows: there was an elongated freely movable tumour about 4 inches by 2 just above and to the right of the umbilicus; on palpating the right iliac fossa it was abnormally empty; there was a good deal of tenesmus, also the passage of a little liquid fecal matter with some blood and mucus; there had been slight vomiting, the temperature was about 100, but the child's general condition was good. The child was at once anaesthetised, and salt solution to the amount of about 20 ozs. slowly injected into the rectum. After this on palpation the tumour was distinctly diminished in size, but the abdominal distension was so great as to render further injection of fluid undesirable. Laparotomy was at once performed, the incision about two inches long being made over the site of the tumour; the latter was immediately seen to be an ileo-cæcal intussusception, this was reduced quite easily with very slight hæmorrhage as slight adhesions had already begun to grow between the peritoneal coverings. The abdominal cavity was then filled with hot salt solution and the wound closed. The operation lasted about eight minutes. Mr. Beale said that he much preferred the injection of hot salt solution when merely used as a preliminary to operation; he considered that it was safer to operate on every case because although the salt solution might partly reduce the intussusception it rarely did so entirely; he thought that even in very young infants a rapidly performed laparotomy was much less risky than the prolonged anaesthesia necessary for the slow injection of fluid into the rectum, and subsequent manipulation through the abdominal wall. As regards the feeding of the infant after operation in this case, Dr. Still suggested that the mother should attend regularly and have her milk drawn off with a pump. This milk served as the child's sole nourishment for the first three days after operation. Humanised milk was then gradually substituted, and upon this the child did very well. Restlessness was combated by the administration of Dover's powder in one grain doses every two or three hours.

It is satisfactory to state that the child made an uninterrupted recovery, leaving the hospital a fortnight after the operation.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, MAY 9, 1900.

A BRITISH MEDICAL ASSOCIATION DISPUTE IN MELBOURNE.

News has come to hand from Australia of a disturbance that has recently taken place in medical circles at Melbourne. The local branch of the British Medical Association of that city have rejected or failed to confirm the resolution of their Council as to the expulsion of a member, whereupon the whole Council handed in their resignation. The question thus raised is one of some importance from various points of view. The origin of the whole affair lay in the alleged connection of Mr. H. M. O'Hara with a company formed for placing on the market a patent called "Silenette." The preparation in question was intended for uses publicly referred to in the pulpit by a dignitary of the Church as "intended to defeat the primary end of marriage." Whatever views a medical man may hold as to the limitation of families he will certainly act unwisely, both in his own interests and in those of the honourable profession to which he belongs, if he allow his name to be connected in any way whatever with the sale of appliances of the kind mentioned. At the same time we must be careful not to allow sentiment and emotion in any way to thwart the path of justice, which must ever be guided by evidence and by calm reason. From this standpoint we propose to consider the case of Mr. O'Hara, so far as the facts have been placed at our disposal by "Our Own Correspondent" at Melbourne and by the newspaper reports to hand. The first official step taken by the Council was to ask Mr. O'Hara whether he had any connection with the company promoting the patent or the circular issued by the company. Mr. O'Hara denied any connection in either instance. The Council invited Mr. O'Hara to explain the appear-

ance of his name in certain legal papers belonging to the company. Mr. O'Hara admitted having signed a document, which he did not read, purporting to be his resignation of any supposed rights in the "powder." He admitted that he had used the stuff for some years past, but its composition was known to others, and he emphatically denied having had any interest in the business at any time. The Council seem to have come to the conclusion, nevertheless, that Mr. O'Hara's name appeared in several documents as a shareholder, and recommended that his name should be struck off the membership roll of the Association. Thirteen out of fifteen members are said to have voted for that course, while two others were in favour of the milder measure of an invitation to resign. In accordance with a law of the Association this recommendation of Council required to be confirmed by three-fourths of a meeting called for that purpose. The meeting was summoned, but the motion for the expulsion of Mr. O'Hara was supported by 31 members while it was opposed by 34. The statutory three-fourths majority was therefore not obtained, and the decision of the Council was stultified. This support of Mr. O'Hara by a large section of his brother-practitioners argues a considerable weight of opinion in his favour, and renders it imperative that the evidence upon which the Council based their action should be made public. The Council decided that Mr. O'Hara was a shareholder in the Silenette Company. Mr. O'Hara, we gather, repudiated that assertion by affidavit, and was supported therein by the sworn deposition of other gentlemen to the same effect. That issue appears vital to the position of both parties, and is a mere question of evidence. At the special meeting it was asserted that Mr. O'Hara had three times applied to the Council to see the evidence upon which they were acting, but had each time been refused. If that be the case the action of the Council must be regarded by all candid men as high-handed in the extreme and contrary to the first principles of ordinary justice. The special meeting insisted upon the production of evidence, which turned out to be documentary proof that Mr. O'Hara had received a number of shares for his interests and rights in the invention, a position which we have already seen was directly contravened by Mr. O'Hara's statutory declaration. The Council then took the extraordinary step of resigning in a body. By so doing they certainly testified to the strength of their conviction but this action does not affect the *crux* of the whole affair—namely, whether their action was based upon evidence such as would have satisfied a court of law. Evidently there is a wide divergence of opinion upon this point among the members of the branch, who have an undoubted right to form their own independent opinion. The Council appear to have held out the threat not only of resignation in case of failure to carry their recommendation but also of the wrath of the parent association. Although the right to manage their own affairs is left to each branch, yet it seems probable that the Melbourne

dispute will ultimately be referred to the London Council. In that case it will be well to remind all concerned that the code of colonial medical ethics ought not be too rigidly assimilated to that enforced in the United Kingdom. While one has not a shred of sympathy with medical men connected with or trading in questionable nostrums or articles, yet on the other hand it cannot be doubted that a large number of our professional brethren even on this side of the ocean are shareholders and directors in companies for "running" spas, medical requisites, foods, proprietary drugs, and various other ventures more or less directly concerned with medical wants and needs. Anyone who cares to dive into the companies' lists at Somerset House will find much to interest him in this direction. It will be well to approach the Melbourne question with caution. Medical men have been too much in the habit of surrendering their destinies to the handling of more or less irresponsible councils, and it is to be hoped that the day of a more popular system of government is at hand.

SLIPSHOD DIAGNOSIS.

RHEUMATISM is sometimes described as a refuge for the destitute in diagnosis. It is certainly a most convenient term, almost as comforting to the patient as "that blessed word Mesopotamia," of which the old lady was so fond. The average patient likes to have something with a name to it, and will pardon much if only his case be properly labelled. Rheumatism and influenza, between them, serve to cloak many diagnostic shortcomings in respect of obscure conditions made up of symptoms which do not, and cannot be made to, fit in with the text-book description of any recognised morbid entity. Pain, observed Hilton in his well-known memoir, is the nerves' cry for rest, but what the patient requires is not so much an explanation as a name, and, accordingly, pains in parts other than the abdomen or thorax, nay, even of the heart ovary, &c., are promptly described as rheumatic. Fortunately this does not of necessity seriously affect the treatment. As the ordinary run of anti-rheumatic remedies are antipyretics and analgesics, these may be trusted to alleviate many forms of suffering, and they are not likely, if used in moderation, to compromise recovery by the action of the *vis medicatrix naturæ*. Unless the term rheumatic be restricted to the articular disease which affects the joints, with the familiar redness, heat, swelling and pain, there is no strict line of demarcation to enable us to define what is, and what is not, rheumatism, and in the vague sense in which it is employed by the public it will cover almost everything. Such a rough and ready diagnosis, however, is hardly what one has a right to expect of a medical man trained to precise observation. By lapsing into the habit of sacrificing scientific accuracy to the desire to save time and trouble, he inflicts what, in the long run, becomes irremediable damage to his sense of discrimination. If, in many instances, the welfare of the patient is not jeopardised thereby, cases not infre-

quently present themselves in which neglect to form a correct diagnosis must be fraught with disastrous consequences. If commencing periosteitis of one of the long bones or incipient tuberculosis of a joint, for example, is glossed over in this way, or if the significance of the referred pains of hip-joint disease be allowed to pass unrecognised, it is evident that serious mischief may be caused by delayed, misapplied, or inadequate treatment. The sensory manifestations of peripheral neuritis again are very frequently treated on routine lines, and as the source of the intoxication is not sought for no improvement, save such as results from the deadening of pain by analgesics, can take place. Another group of affections which lend themselves readily to the description "rheumatic" are the so-called "occupation neuroses." Many of these conditions are amenable to a properly directed treatment for the want of which they remain uncured. Most of them call for mechanical and tonic treatment rather than the administration of the depressing antirheumatic remedies, in other words, a rational treatment is impossible in the absence of a definite diagnosis, and if we are to deserve and retain the confidence of the public, we must devote our energies and intelligence to a conscientious endeavour to ascertain the exact lesions which underlie the symptoms.

LEAD POISONING.

It has been stated that lead poisoning, with all its heavy train of disaster, may be avoided in the manufacture of ware by using a glaze and pigments that contain no lead. That proposition, however, has not met with sufficient support from those engaged in the trade to admit of its being adopted as an axiom in the future regulation of the potting trade. Hence the attention of scientific investigators has been turned for some time past to the limiting of the evil resulting from the use of the dangerous metal in question. Briefly stated, the question to a great extent is one of solubility of the particular form in which the lead reaches the body of the workman. It has long been known that "fritted" glazes are far less harmful than those that contain raw lead or its compounds. The fritted glaze is one made of silicates of lead ground into a fine powder. This "frit" is often mixed with a greater or less amount of raw lead material, and its poisonous qualities are thereby proportionately enhanced. In some parts of the Continent, where all the materials of the glaze are applied in a fritted form, lead poisoning is said to be almost unknown. It seems certain that a percentage of workmen will suffer from plumbism so long as lead is used in the making of ware. It is to this factor of susceptibility that one may perhaps fairly ascribe the cases met with among the workpeople of some Staffordshire firms where fritted glaze has been exclusively adopted. These considerations have led to a careful study of the "frits," with a view of determining in what way the danger arose. Professor Thorpe, Principal of the Government

Laboratory, has paid special attention to the point, and recently laid the results of his investigation before the Royal Institution. His main object was to determine the ease with which a frit yields its lead to dilute acids, comparable in their action to the gastric juice. In this way he appears to have adopted the view that it is mainly through the solvent influence of the stomach that lead was enabled to become toxic to the human body. A little consideration will go far to support that view, for many or most of the trade powders that find their way into the food or air passages are insoluble apart from the presence of free acids. The learned professor, as the result of the examination of a large number of English and Continental frits, came to the conclusion that the ease with which lead could be given up to solvents was largely dependent upon the ratio existing between the basic and acid constituents of that material. He found that provided the sum of basic oxides was not more than double that of the silica, the frit, as regarded its lead, did not attain a greater solubility than about two per cent. That amount was independent of the proportion of lead present, and provided that the limiting ratio was preserved the solubility was independent of the nature of the base. The next discovery was of an exceedingly practical nature. He found that by treating the frit in process of grinding with a weak solution of hydrochloric acid practically all the lead which would otherwise be soluble could be removed, the residual frit having substantially the same composition as before treatment. For example, a frit containing upwards of 53 per cent. of oxide of lead, giving 2 per cent. of soluble lead, had its solubility diminished by the dilute acid treatment to 4-10 per cent. Reduced to a plain statement it is possible to remove from the frit by means of dilute acid that part of the lead that would be soluble in the juices of the stomach. If we may conclude that Professor Thorpe's process will render all frits insoluble, and therefore innocuous, there will be no further excuse for the use of dangerous lead frits by potters. The Home Secretary is apparently so well satisfied of the security of the position that he has called upon the manufacturers to discontinue the use of raw lead, and in the case where lead must be employed in glazes, to use it only in the form of frits of a standard limit of solubility. The whole question offers an interesting illustration of the way in which progressive scientific knowledge may be made available in the prevention of disease.

Notes on Current Topics.

Bolognini's Sign in Measles.

THIS interesting phenomenon is worthy of note by general practitioners, by whom the majority of cases of measles are seen—that is to say, when the friends of the patients deem the attack worthy of medical attention. The essential feature of the sign is a peculiar sensation of friction, which is felt when the finger-tips are rubbed over the abdomen with pressure

at first gentle and then gradually increased in force. According to Bolognini, it is possible to make out this sensation, which he ascribes to a morbilliform eruption on the peritoneum, from the prodromal period to the end of an attack. More recently his observation has been confirmed by other investigators. Dr. Koeppen discovered the phenomenon in 154 out of 316 cases, but in his opinion the sensation was rather one of fine crepitation due to the presence of gas in the intestines than of friction. The point raised is of interest in its possible connection with Koplik's early diagnostic spots found on the mucous membranes of the cheeks and lips in nearly all cases of measles. They are round, whitish, slightly raised, from 2 mm. to 6 mm. in size, with a reddish centre, and are peculiar to measles. Fortunately measles is so well-marked a disease as rarely to be mistaken for any other complaint. Its non-fatal nature, moreover, under decent conditions of environment, detracts from the value of diagnostic signs. At the same time the sign of Bolognini cannot fail to be of interest to the intelligent practitioner of medicine.

The Prohibition of Expectoration.

WE are often being told that the regulation of expectoration in public thoroughfares for which we are clamouring is already a *fait accompli* in the cities of the United States, indeed a contemporary recently went so far as to state in addition that the law was "rigorously enforced." The *New York Medical News* "only wishes such were the case," on the contrary, we are reproached with having mistaken the will for the deed. We shall not be surprised if, after all, our Transatlantic cousins set us a much-needed example in this matter, for the nuisance is even greater with them than with us. The real difficulty, however, is not to pass such a law but to enforce it. Legislators have a praiseworthy dislike to the creation of fresh offences, and we are probably not yet within measureable distance of a penal edict having the suppression of this disgusting habit for its object.

Compensation to Asylum Attendants.

IT is announced that a South London parish is collecting signatures to a petition to be sent to the Local Government Board with regard to the compensation of attendants in public lunatic asylums injured in the discharge of their duty. At present no power exists to grant such relief, and the proposition urged upon the Government is that Poor-law authorities should be authorised to make adequate awards under such circumstances. This demand appears to be more than reasonable; it is a simple act of justice. Of recent years the principle of compensation to servants injured in the course of their occupation has been widely recognised, and will doubtless sooner or later be extended to such classes as sailors, laundresses, and domestic servants. There is no apparent reason why attendants on the insane should be excluded

from the purview of this most salutary principle. As a class they are exposed to peculiar dangers, while their work is of a highly skilled and exacting nature. When one of their number, then, is partially or totally disabled by accident or by the attack of a lunatic patient he should clearly be entitled to compensation at the hands of his employers. Perhaps it is not strictly correct to say that no power of granting compensation exists. In several instances the medical superintendent of an asylum has been seriously injured by a patient and has received a liberal retiring allowance. In this indirect way a local authority may grant compensation, although any exercise of liberality in that direction would of course not apply to attendants whose service had not been long enough to entitle them to a substantial award.

The Mortality from Measles.

MEASLES is generally regarded, not only by the public, but also, it is to be feared, by practitioners, as a disease unattended by any particular gravity, a fact which explains its exclusion from the list of notifiable diseases. This view is founded on a misapprehension, for measles alone accounts for nearly half the total number of deaths from infectious disease, if we except tuberculosis. In a recent communication to the Paris Academy of Medicine, Dr. Vallin points out that while the mortality from infectious diseases in general has been steadily falling for some years past, that from measles, on the contrary, has become progressively higher, rising in fact from 679 in 1895 to 904 in 1899. He attributes the diminution in regard to notifiable diseases to methodical disinfection, which is the exception after measles, and is at present even less frequently resorted to than formerly. He refers to the hypothetical case of a child, one of a family, who succumbs to croupous pneumonia following measles at the end of a fortnight's illness. At about this time one or more of the other children begin to develop the disease, and it is evident that if disinfection has not been carried out the later sufferers run a far greater risk of infection by streptococci, pneumococci and other bacteria left by the deceased child, than would be the case if this precaution were insisted upon. There is no doubt that the only means at our disposal of reducing this formidable death-rate is to educate the public in the necessity for taking every available precaution to stem the tide of infection, and from this point of view one of the first steps should be to make measles a notifiable disease.

Heat Stroke and Sun Stroke.

HEAT stroke and sun stroke are not interchangeable terms. The former, according to Dr. Moussoir, is a functional disturbance of the nerve centres due to the circulating blood having attained too high a temperature. This state cannot be induced by an outside temperature under 104° F. acting on the surface of the body as a whole long enough to heat the mass of blood. The particular symptoms by which this condition manifests itself—asphyxial, comatose, apoplectic &c.—depends not only upon the

idiosyncrasy of the victim, but also, to some extent, upon the hygrometric condition of the atmosphere. In sun stroke the clinical manifestations are very similar, but their causation is different. In sun stroke, we learn, the symptoms are due to the direct action of the solar rays on the cranium, the actinic rather than the heat rays being the source of the mischief. For the production of these symptoms a high outside temperature and prolonged exposure are quite unnecessary. When, however, the action of the actinic rays is associated with a high ambient temperature and moisture their combined influence is apt to be rapidly lethal. It follows that treatment should comprise the immediate application of local and general refrigerants—ice, cold water, the wet pack, &c., associated with measures having for object to restore consciousness as soon as possible—flicking, friction, and so on. Lastly, in order to control the thermogenic centres the author advises the exhibition of antipyrine in drachm doses preferably by hypodermic injection.

A Medical Libel Action.

Audax fortuna juvat must have been the motto of the plaintiff in the action for libel brought against the *British Medical Journal*, which was tried last week in the Queen's Bench Division. The plaintiff, himself the editor of the *Verulam Review*, felt aggrieved at being accused of carelessness or ignorance in respect of certain remarks made by him bearing on the terms of the license under which certain experiments on animals had been carried out, and he was ill-advised enough to found thereon a preposterous claim for damages. The practical joker, it is said, is usually the last man to appreciate jokes of the kind played on himself, and *pari passu* the editor of the review in question appears to be unnaturally sensitive to criticism couched in vigorous language. He himself has been in the habit not only of insinuating, but also of asserting, most unworthy things about practical physiologists, for the most part without any foundation, yet the comparatively mild rejoinder in our contemporary seems to have stung him to the quick. It is satisfactory to record that, for once in a way the jury took a common-sense, judicial view, and gave a verdict in favour of the defendants.

Theatre Doctors.

In many foreign countries directors of theatres are compelled by custom, if not by law, to provide medical assistance in anticipation of accident or sudden illness among the audience. The managers of a certain theatre in Boston, U.S.A., writes a correspondent, have adopted a novel method of making this provision, or, at any rate of announcing it. In the lobby there is a board upon which, every night, the names and seat-numbers of the physicians in attendance at the performance are inscribed so that they may be called out when their services are required. The plan is said to work well, but it is not likely to become popular in this country. There can be no objection to the management engaging the services of a medical man for this

purpose, but it would hardly be necessary or desirable to blazon forth his whereabouts and titles, and there are many and weighty reasons why perchance the chance medical visitor might not wish to have his presence made thus public.

The Fellowship of the Royal College of Physicians, London.

THE election of Fellows of the Royal College of Physicians, London, took place at the last Comitia of the College on the 26th ult., and the list of successful candidates has no doubt caused some heart-burning among a large number of the members by whom the honour is coveted. As showing the diversity in the period of membership represented by the successful candidates, we may point out that the senior member on the list obtained his membership diploma as long ago as 1875, while, on the other hand, the junior member, who was successful, received his diploma of member, as recently as 1894. It is almost absurd to suppose that the distribution of honours upon this occasion has been fair, if the matter be looked at from the point of view of merit. If the standard of merit be taken in the present distribution it is difficult to understand how the Council made their selection, for there are many members of the College—to be more exact we will say at least several—whose claims for the Fellowship have been repeatedly recognised and repeatedly ignored by the Council. But if justice be concerned in the matter, surely it were only just that the Council should reward the members of the senior staff of the large hospitals in London who have worthily attained their position by work from which both the profession and the public have profited, and yet some conspicuous examples of the delayed honour in this connection are known to exist. Apparently no recognised rules are observed by which the bestowal of the Fellowship is regulated, and consequently the only conclusion to be drawn from this state of affairs is that the great, if not the only, element in the case is that of personal interest. Upon the whole the election this year at the College reminds us of the Oriental proverb: "Blessed is the man who expects nothing: yea, verily he shall not be disappointed." Perhaps, therefore, those members upon whom the Fellowship has not descended after many years of honourable waiting, had better take this proverb as their consolation.

The Elections at the Royal College of Surgeons, Ireland.

ON Tuesday, the 1st inst., the Council of the College proceeded, in accordance with the charters, to elect examiners for the ensuing year, and in another part of our issue we give the names of those selected. As is usual the chief contests were for the examinations in anatomy and in surgery. For the Anatomical Court Professors Bermingham, of the Catholic University, and Fraser, of the College School, were successful, but Dr. Edward Taylor, the newly-appointed surgeon to the Meath Hospital, came very near to success. For the Surgery Court Mr.

Croly, who has held the office for the past, and in many previous years, was chosen, and Professor Stoker, of the College School, was taken as his colleague. Mr. Conway Dwyer, of Jervis Street Hospital, who held the examinership of the past year, failed to secure re-election. The examinership in physiology was regarded with much interest in view of the reiterated complaints of the excessive severity of the examination in this subject. The seat occupied for many years past by Professor Scott was, on this occasion, contested by Dr. Edward Ledwich, of Mercer's Hospital, but Professor Scott retained possession by a small majority. A second examinership in the same subject went to Dr. Coppinger, of the Catholic University, without a contest. Dr. MacFeeley, of Mercer's Hospital, was chosen to examine in pathology for the Fellowship. As examiners in ophthalmology Messrs. Arthur Benson and Louis Werner were selected, Mr. Maxwell losing his seat. The changes in the examining courts for other subjects were unimportant.

The election of a new President, Vice-President, and Council of the College will take place on June 4th. Mr. Swan retires from the presidential chair and will, without doubt, be succeeded therein by Mr. Myles, the Vice-President. For succession to the latter office Mr. Lambert Ormsby, of the Meath Hospital, and Mr. Heuston, of the Adelaide, have long been competitors, and the contest is expected to be close. As regards the Council there will, no doubt, be many candidates. The outgoing President will certainly be elected to the seat vacated by Mr. Myles if he chooses to offer himself. The annual meeting of the Fellows to receive the report of the Council will be held on the previous Saturday, June 2nd.

Music as a Galactagogue.

WE have heard a good deal at one time and another of the therapeutical effects of music, indeed, the Guild of St. Cecilia was founded for the purpose, we believe, of carrying out this system of treatment. We learn, on the authority of a well-known agriculturist, that music exerts a physiological action on cows in respect of the secretion of milk. At a recent meeting of dairy farmers, it was solemnly stated that music, suitable in quality and "administered" at the right moment, was a never-failing means of increasing the proportion of cream in cows' milk. Now, galactagogues are notoriously uncertain in their action, and if there be any truth in this startling statement, nursing mothers whose lacteal secretion is lacking either in quality or quantity ought to take subscription tickets to all the fashionable concerts, failing which a box at the opera occasionally might possibly answer the purpose.

It has been decided in the higher courts of the United States that surgical instruments imported by a hospital or similar institution for the instruction of medical students are entitled to entry duty free under an Act of 1894 which exempts "philosophical and scientific apparatus, utensils and preparations" from tariff duty.

Midwifery in Bulgaria.

ACCORDING to Dr. G. Ivanoff, the practice of midwifery in Bulgaria sadly needs reform. In a thesis he read at Lille (*Arch. Os. de Méd.*) he mentions that there are no trained midwives in Bulgaria. The parent or other near relative of the patient selects a suitable aged female, whose sole qualification for the office of midwife is that she has borne children. A month before the labour this dangerous attendant comes on the scene, when she counsels the use of precautionary measures against miscarriage or premature birth. These dangers are to be warded off by wearing a girdle of wool, gathered from the under-growth of the forests where sheep are pastured. A girdle of different coloured wool is also made for the child. To facilitate the labour, the woman is taken by the shoulders and made to dance in the place. When the labour is difficult the midwife introduces two fingers of her hand, or the hand itself, "to make the way of the baby." If the birth does not follow the poor patient is compelled to dance. Should rupture of the soft parts occur, cow dung is packed into the wound. After the birth is completed and the necessary nursing duties fulfilled, the midwife washes her hands, but not until then. That the mortality of parturient women and newly-born babes is high in Bulgaria, need not excite surprise.

A Remarkable Law Suit.

TROUBLESOME litigation is not unknown to medical practitioners in this country, but for litigious monstrosities the United States certainly hold the palm. In a suit recently brought before the Illinois State Supreme Court an infant sought to recover damages to the extent of 50,000 dols. for injuries sustained prior to birth. It appears that on the admission of the mother, already in labour, to St. Luke's Hospital, her foot was caught in the lift and severely injured. When the child was born its left side, foot, and leg were paralysed and deformed, and this was alleged to be due to the maternal injury. The defence was based mainly on the technical ground that as at the time of the accident the child could not be said to have an independent existence it was incapable of maintaining an action at law. The result is not given, but we presume the case was dismissed on this purely technical ground, as otherwise it would not have been difficult to demonstrate the impossibility of a maternal impression producing deformity at such a late period of pregnancy.

A Moot Point in Adulteration.

AN interesting legal point was raised last week before the magistrates in Belfast in a prosecution of a Union milk contractor for having added water to his milk. No defence was put in to this charge, but the milkman's counsel urged that the contractor could not be made responsible, inasmuch as he was, at the time of the delivery of the milk, a bankrupt. He had, in fact, been decreed a bankrupt on the very day of the delivery of the milk, and the Court gave its adjudication at midday, while the samples of milk taken for the purposes of the prosecution were not

collected until 5.15 p.m. The prosecutors urged that the bailiff of the Court did not enter into possession of the premises until 7.30 p.m., and that, until that hour, the milkman was not legally bankrupt. Under the circumstances the magistrates reserved judgment until they shall have found precedents to decide the question whether the moment of adjudication or the moment at which the bailiff takes possession is the exact period of bankruptcy.

Consumptive Sanatoria in Canada.

THE care of phthisical persons is about to be made a State affair in Ontario. A measure is in process of being passed by the Government by which sanatoria for the treatment of tuberculous patients will be erected, partly at the expense of the State; the management and control of the institutions will afterwards be placed in the hands of trustees elected by the various municipalities. Although, it is stated, that the Ontario government have not been too generous in providing the means for the erection of the sanatoria, it cannot be denied that they have taken a step in the right direction. No doubt can be felt that municipal sanatoria for the treatment of the tuberculous poor should be organised in this country. A great need for such institutions exists, for while the well-to-do classes can avail themselves of the private sanatoria already existing, the poor have no such advantages within their reach.

A Mosquito-Proof House.

EXPERIMENT constitutes the final court of appeal in scientific matters. The theory of the spread of malaria by mosquito-bites naturally suggests the possibility of prevention of the malady by excluding the particular species of that insect to which infection has been traced. An interesting experiment on these lines is about to take place at Cervellata, about thirty minutes' run by rail from Rome. The district has been chosen because of its evil name for malaria, indeed, it is distinctly and emphatically stated that for malarial conditions "no place could be worse." That is to say, one night's sojourn there under ordinary conditions would infallibly mean an attack of the fever. The Italian surgeon, Dr. Sambon, and an Englishman, Dr. G. C. Low, have determined to spend the whole of the malaria season, from June to October, in Cervellata. They have neither of them suffered from malaria, and are, therefore, fit subjects for experiment. Their plan of campaign is to live in a specially constructed mosquito-proof house, in which they will shut themselves up securely every night, as that is the only time there is any chance of being bitten by the evil species of mosquito. The house is to be a wooden building with double casements, all covered with special zinc mosquito-proof netting. There are double doors and curtains in the entrance porch, and mosquito nets for the beds. The house has no chimney. The experiment, if successful, cannot fail to carry conviction to the minds of the non-scientific world. It has been not inaptly described as of a dramatic nature, but so too would be the extinction of so terrible a scourge as malaria.

Where is the Line to be Drawn?

THE code of ethics in the medical world is curiously unstable and shadowy. Still less satisfactory is the regulation of the actions of medical men by the General Medical Council. Indeed, it is fairly well recognised that a medical man who has not entered his name on the *Register* may snap his fingers in the face of the Council, so far as discipline is concerned. A point on which it would be interesting to have some definite information is the attitude of that august body with regard to "health" columns in lay newspapers and journals, signed by medical men. Some time since the present writer sent information to one of the Defence Societies of a qualified man who gave advice and could be consulted at small fees through the medium of a Sunday newspaper. The reply was that no action could be taken in the matter. Quite recently a correspondent has drawn attention to an article of the kind which appears in a magazine entitled *The Lady's World*. It is signed by the full name and qualifications of a member of the English College of Surgeons and a licentiate of the College of Physicians. This contribution, among a mass of miscellaneous medical information, interleaves references to a patent food for children, a meat extract, a patent wadding, and a soap. Specific advice is given at the end in answer to correspondents. As the undesirability of such articles seems fairly apparent, they cannot raise the dignity of an honourable profession in the eyes of the public. In view of past policy of the General Medical Council it would be interesting to learn their opinion as to this form of publicity.

A Silent Apotheosis.

IN these days of fussy self-advertisement, when the fierce light of publicity beats down upon the medical no less than upon other professions, it is somewhat curious that a perfectly legitimate and desirable opportunity of a public recognition of services rendered should be relegated to the cold shades of neglect. Such appears to have been the case, however, at University College Hospital. Some time ago we were enabled to give an early announcement of the retirement of Mr. Christopher Heath and Dr. Sidney Ringer. It was naturally imagined that the usual custom of a formal testimonial and a farewell dinner would be observed in the case of these distinguished members of the profession, whose names have been so long and intimately connected with the history of University College. The resignation has taken place, and also the dinner and presentation have become accomplished facts, but the latter have been of a purely private nature, so that past residents, students and friends have had no opportunity of taking part in the movement. The reasons for this privacy are not easy to conjecture, but the suggestion that public farewell dinners lead to loss of practice may be at once dismissed from the category of likelihoods. Dr. Shaw has been appointed to the post of assistant physician left vacant by promotion to the full physiciancy. Until recently he held the

post of resident Medical Officer at University Hospital. The vacant assistant surgeoncy has not yet been filled up.

Board School Diphtheria.

THE question of the increase of diphtheria and its relation to board schools is one that cannot be staved off much longer by vague general assertions. Either the disease is or is not spread by the bringing together of large numbers of children under conditions where they are exposed to the likelihood of infection. At any rate, no steps whatever exist under ordinary circumstances to exclude cases of sore throat a certain portion of which must infallibly be diphtheritic, and other communicable disease. In the columns of the *MEDICAL PRESS AND CIRCULAR* this defect in the present system of national education has been repeatedly discussed and condemned. An emphatic illustration of school-bred diphtheria was recently given by Dr. Campbell Pope to the West London Medico-Chirurgical Society. For seven years after starting practice in the Shepherd's Bush District he did not see a single case of diphtheria. A Board School was then built upon the site of a marshy pond, so low-lying that adequate drainage was not obtainable, "and a great collection of impurities took place in the unhealthy foundations." If that state of affairs had not been remedied, there is ample room for departmental inquiry into the question. Dr. Pope goes on to say that soon after the school was founded "diphtheria soon started, and there it has remained ever since. Nearly all our cases of diphtheria came from the district supplied by this school." A weighty indictment like this from so responsible a quarter cannot be overlooked by the most optimistic of Departmental officials.

The International Medical Congress, Paris.

WE are informed by the honorary secretary in London that the Executive Committee in Paris reports that an arrangement has been concluded with the Commissary General by which members of the Thirteenth International Congress of Medicine to be held at Paris from August 2nd to 9th will be admitted free to the Exhibition. A special ticket entitling members to this privilege will be issued at the offices of the Congress from July 31st.

Professional Secrecy.

A FEW days since a case was heard before the Nottingham bench of magistrates in which they were asked to revoke or set aside a maintenance order on the ground of the adultery of the wife, in whose favour it had been made. Dr. Hunter, who had attended the wife, was called on behalf of the applicant to prove the nature of the illness, but declined to reply to the questions put to him on the ground that to do so would be a violation of the confidence reposed in him, and would moreover expose him to an action at law and sundry other disagreeable contingencies. After deliberating, the magistrates declined to order him to answer the questions, and adjourned the further hearing of the case in order that an appeal might be made to a higher court. Whatever

this decision may be, Dr. Hunter will have earned the esteem of the profession by the dignity of his attitude and the trouble he has gone to to obtain a judicial pronouncement on a very important and delicate point. We shall have occasion to revert to the question later on, but meanwhile we take the opportunity of approving Dr. Hunter's stand.

Milne Edwards.

THIS distinguished scientist, the most noteworthy zoologist in France and almost in Europe, died a few days ago after prolonged illness. He succeeded his father as director of the Natural History Museums and of the Jardin des Plantes, and professor of zoology in the School of Pharmacy. He attained the distinction of being a member of the Academie de Medecine and also that of Science. He was, moreover, an officer of the Legion of Honour.

The New Edinburgh Professor of Medicine.

DR. JOHN WYLLIE has been appointed by the Cuators of Patronage to the Chair of Practice of Physic in the University of Edinburgh. His election will be a popular one among certain circles, and is a well-merited reward for past devotion to duty and success in teaching. Without doubt, many would have been better satisfied had a more junior man been appointed, but all can recognise the sterling worth of the successful candidate.

A Musical Keeper of Lunatics.

AT the last meeting of the governors of the Omagh Asylum the Resident Medical Superintendent reported that one of the female keepers had left the Asylum after a few days' residence, giving it as her reason that no piano was kept for the attendants.

THE latest suggestion for the performance of vaccination is to imbibe gelatine discs with the vaccine, and to cause these to adhere over the site of the puncture, ostensibly with the object of precluding the possibility of infection. *Quis custodiet ipsos custodes.* It would first be necessary to secure the sterilisation of the discs, and this would be a quasi-impossibility.

THE annual dinner of the Sanitary Institute will be held on Friday next, the 11th inst., in the Venetian chamber of the Holborn Restaurant, when the chair will be occupied by the Duke of Cambridge.

THE annual congress of the Institute of Public Health will be held at Aberdeen from the 2nd to the 7th of August, and it will be presided over by the Earl of Aberdeen.

PERSONAL.

DR. J. KINGSTON FOWLER will deliver the Annual Oration before the Medical Society of London on Monday, the 21st inst.

MR. J. S. CROWE, L.R.C.P.I., of Kensal Rise, has been elected chairman of the Willesden District Council for the ensuing year.

SIR HENRY KARBEN will open the new "open-air" wing for 40 patients at the North London Hospital for Consumption, Hampstead, on the 20th prox.

DR. K. M. ROBERTSON, of Brechin, has been presented with an illuminated address and a purse of sovereigns on his leaving to take up practice elsewhere.

DR. JOHN WYLLIE, consulting physician to the Edinburgh Royal Infirmary, has been appointed to the chair of medicine in the University of Edinburgh, void by the death of Sir Thos. Grainger Stewart.

SIR JOHN BATTY TUKE was, as we anticipated, elected the member for Edinburgh and St. Andrews' Universities, last week, without opposition; Mr. J. M. Barrie withdrawing his name before the date for nomination.

THE Committee of the Berwick Home, Rathfarnham, have appointed Mr. Henry Gray Croly, Past President Royal College of Surgeons, and Senior Surgeon of the Royal City of Dublin Hospital, Consulting Surgeon to the Home.

DR. APOSTOLI, the pioneer of the now discredited electrolysis treatment of uterine fibroids in France, is dead. He was a man of much originality, who, though he did not belong to, indeed, but was regarded with honour by the official and professional *mondes*, achieved a considerable measure of success as a practitioner, if not exactly as a scientist.

MR. ARNOLD F. HILLS has presented to the Hospital of St. Francis a complete hospital of eight beds, which he has just erected at a cost of about £2,000, close to Epping Forest, Essex. The plans were suggested by designs brought by Dr. Oldfield from Geneva, in which a modified form of the open-air treatment will be extended to suitable surgical as well as medical cases.

THE following members of the medical profession have been appointed magistrates for New South Wales:—Malcolm L. Cameron, M.D., Ch.M., of Clarence River; Henry Wm. Devlin, M.R.C.P.Irl., of North Sydney; Thomas C. Fisher, M.D. Dub., of Boivral; Frank St. B. Gaden, L.R.C.P. Ed., of Grenfell; William Irwin, M.B., M.S., of Singleton; James Kearney, L.K.Q.C.P., of Parramatta; George P. Lambert, M.R.C.S., of Berrima; and Alex. J. Park, M.B., C.M. Ed., of Narrabri.

THE profession in Dublin will learn with satisfaction that Dr. Henry Colpoys Tweedy, physician to Stevens's and Cork Street Hospitals, is recovering steadily from the very alarming illness from which he has suffered for some months. We understand that he was, originally, attacked with influenza and pneumonia; when recovering from these conditions he developed phlebitis, and, it is supposed, a clot in some part of his circulatory system. He is now, we are glad to understand, recovering strength at a health resort in the South of England.

Hospital Beds for Wounded Soldiers.

MADAME ALBANI will sing and the Princesses Christian and Victoria will be present at a concert at Reading on the 19th, in aid of a fund for endowing six beds for Berkshire soldiers and sailors in Princess Christian's Homes at Bisley.

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

A NOTE ON CONGENITAL LARYNGEAL OBSTRUCTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—A specimen of the larynx from a suddenly fatal case of this nature was shown at the Harveian Society by Dr. McIlraith, and is recorded in the issue of THE MEDICAL PRESS AND CIRCULAR, May 2nd. In the exhibitor's opinion death was due to laryngeal spasm. In the discussion which followed, Dr. Lack is reported to have said that "the specimen was an extremely interesting one to him as it was a further proof of the correctness of the views Dr. Sutherland and he had expressed as to the pathology of this disease." This is not quite clear to me, since in the article containing these views, (*Lancet*, Vol. II., 1897, p. 651), I read that "the theory that the affection is in any way a spasm seems to us untenable." Dr. Lack is further reported to have said that the case was "quite fatal to the hypothesis of those who had ascribed the disease to adenoids."

I believe I am responsible for the first suggestion that laryngeal stridor—laryngismus stridulus—will often be found to be due to adenoids—*British Medical Journal*, Vol. 1, 1890, p. 357—and this view has been since repeated by Drs. Robertson, Eustace-Smith, and Greville Macdonald—*Journal of Laryngology*, 1897, p. 308—but I am not aware that anyone has asserted that adenoids are responsible for any definite laryngeal "obstruction" such as is represented by pressure on the windpipe by the thymus gland or a new growth. But even if it were so, the case in question cannot be considered "quite fatal to the hypothesis" seeing that Dr. McIlraith reports that "the mucous membrane of the nose and naso-pharynx was generally relaxed, and that there was some small amount of post-nasal adenoids present," and he later argues the question as to the extent these adenoids may have contributed to the laryngeal spasm; concerning which as Macdonald has noted, "in some patients the removal of an absurdly small enlargement of the pharyngeal tonsil may induce extraordinary improvement"—a corollary of the view that gravity of symptoms is not always proportionate to the amount of overgrowth.

It is somewhat curious to further remark in this connection that Dr. Lack, who denies the relationship of laryngeal stridor and nasal obstruction, exhibited a case to the Laryngological Society which was, in his judgment, "one of laryngeal spasm due to adenoids," which he proposed to remove. (*Journal of Laryngology*, 1898, p. 303).

I read that the child "showed signs of congenital syphilis," but I do not read that any specific treatment was adopted to combat this dyscrasia.

Finally the spasm is described as congenital, but no symptoms were shown until the child had attained the age of six weeks, and, assuming a syphilitic element, this delay might be explained by development of the syphilitic manifestations. The practical deductions from these few observations is that not one but many causes may contribute to congenital or infantile neuroses of the larynx affecting respiration, and that it is unwise to assert that the absence, presence, or predominance of one factor in a given case is necessarily fatal or confirmatory of its existence and importance in others.

I am, Sir, yours truly,
LENNOX BROWNE, F.R.C.S.Ed.

Mansfield Street, W.

OPPOSITION TO THE MIDWIVES BILL.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I wish to call the attention of your readers to the fact that I have published, in leaflet form, "Reasons Against the so-called Registration of Midwives" and that such may be obtained from Messrs. Meek, Thomas and Co., Cable Street, Liverpool, at two shilling per 100 copies.

If each practitioner will write to the M.P. for his division asking them to strongly oppose the Bill, and enclose a copy of the "Reasons Against," this will prevent the Bill from passing. If each practitioner will also send a circular letter to all his women patients, asking each to write to the divisional M.P.'s, and sending such patients a copy of the "Reasons Against," this will also greatly help.

I suggest this latter action because the promoters of the Bill are giving it out that ours is a mere trade union opposition. If we can induce women to write, this will neutralise this wrongful and contemptible suggestion.

I am, Sir, yours truly,

R. R. BENTON.

Liverpool, May 6th, 1900.

Literature.

FUCHS' OPHTHALMOLOGY. (a)

THE appearance of a second edition, in English form of this valuable and important work, eloquently testifies to the favour with which it has been received in this country and America. Its popularity is well deserved, and of all the text books on ophthalmology now in the market, we believe it to be almost the best. One proof of the high position in this regard to which it has attained is the frequency with which its author is quoted in other text-books. To name only a single feature it is significant to note the use which has been made of Fuchs' instructive diagram, depicting the three kinds of excavation of the optic disc. Too comprehensive, perhaps, for the ordinary student of ophthalmology it nevertheless furnishes the advanced student and the practitioner with all the latest facts relating to eye diseases, rendering it an invaluable work of reference. Dr. Duane, in this second edition, has inserted two new sections upon heterophoria, and upon the use of homotropine and other cycloplegics, and the general subject of the correction of refractive errors, for which he makes himself responsible. The value of this edition is further enhanced by the addition of upwards of 80 illustrations over previous issues. As a thoroughly scientific, up-to-date, treatise upon ophthalmology we can strongly recommend this edition of Fuchs to British students and practitioners.

STONHAM'S SURGERY. (b)

THE publishers of manuals for practitioners and students do not always pay sufficient attention to the comfort of students in arranging publications for their use. It is absolutely essential, from this point of view, that the type should be fairly large, adequately leaded, and well printed. A less important but nevertheless desirable feature is the avoidance of gigantic volumes, unwieldy to manipulate and consequently inconvenient to hold. Lastly, the paper should be opaquely white and devoid of glaze, in order to obviate all needless strain on tired optics.

With regard to the typographical proviso, we have nothing but praise to utter in respect of the work under consideration, and the division into three volumes of approximately equal size is a happy idea for which students and others will be duly grateful. There is, however, a fly in the apothecary's ointment, and it takes the form of a glaze. No doubt this accentuates the beauty of the illustrations, but, though slight in degree, it constitutes a distinct drawback for the reader who has diligently to con the text, and we trust that this

(a) "Text-book of Ophthalmology." By Dr. Ernest Fuchs, Professor of Ophthalmology in the University of Vienna. Authorized translation, revised from the seventh enlarged and improved German edition. By A. Duane, M.D., Assistant Surgeon, Ophthalmic and Aural Institute, New York. With 277 illustrations. Second American Edition. London: H. K. Lewis, 1899.

(b) "A Manual of Surgery." By Charles Stonham, F.R.C.S. Eng., Senior Surgeon to the Westminster Hospital, Lecturer in Surgery and Clinical Surgery, Teacher of Operative Surgery, &c., &c. In three volumes. London: Macmillan and Co., Limited, 1899.

American example will not be followed to any extent in this country.

The first volume deals with general and constitutional conditions—the degenerations, inflammation with its sequelæ, suppuration, abscess, and ulceration, and gangrene. A separate chapter is devoted to surgical bacteriology, which has now become a very necessary department of surgical knowledge. The author has boiled down the generally received views concerning bacterial modes of action, their properties and salient characteristics, and gives diagrammatic drawings of their appearances. In reference to these illustrations we would suggest the propriety of giving, approximately at any rate, the degree of magnification which they represent, or else of drawing them all on the same scale to admit of comparison. It is a matter of regret to us that the author gives his sanction to the misuse of the term "tubercular" to designate the tuberculous process. The subject is treated quite superficially, no specific directions being given for clinical methods of detecting bacilli. Glancing at the chapter on gonorrhœa, the author's directions for treatment may suffice for the student, but they are not likely to prove of much assistance to the practitioner. He inculcates the routine treatment by the balsams and attaches what appears to us to be an overweening importance to injections. He assumes that sandalwood oil and the like act "directly upon the urethra," whereas Ricord proved many years ago that their action on the inflammatory process is due to their presence in the urine which thus acts the part of a topical germicide. We question, too, the value of tepid water injections in the acute stage in view of the risk of extending the sphere of inflammation thereby to the deeper parts.

Volume II., which is devoted to "Injuries," naturally commences with a chapter on antiseptic surgery, a very appropriate introduction to the subject. Some ten pages are allotted to the description and treatment of gun-shot wounds, a branch of surgery on which the author may wish to dilate further on his return from South Africa, fortified as he will need be by valuable experience of the effects of other and more modern weapons than the Lee-Metford and Martini-Henry.

Vol. III. deals with regional surgery, commencing with diseases of the blood-vessels, and the treatment of such among them as admit of surgical remedy. We note with some surprise that the author unequivocally declares himself in favour of the use of Murphy's button or some similar contrivance in operations having for object intestinal anastomosis, disregarding the very strong current of surgical opinion which has set in within the last two or three years in favour of direct union. He is, of course, entitled to his opinion, but it would have been fairer to state the very tangible drawbacks following the use of any form of mechanical contrivance, not indeed that the operating surgeon is likely to be guided by book lore on such a point, but in order to enable students to parry the crotchety examiner whose leanings may be in one or other direction. In respect of the etiology of appendicitis the author is hardly up-to-date for he omits all reference to the essentially infective nature of the appendicular lesion, a point of great practical importance in that it brings all cases into one great group, and explains how it is that the mild case of to-day may be the critical case of to-morrow. He lays great stress, too, on "McBurney's point," a point of which it has been said, in regard to diagnosis, that "it were better that he had never been born," in other words, as a guide to diagnosis, this point is useless, though of course the student ought to know that it has been specially precognosed.

On the whole we have reason to congratulate the present generation of students and surgeons *in posse* on this addition to their sources of instruction. The author's style is crisp and to the point, and he is as brief as circumstances allow. The illustrations are fairly numerous, and the general "get up" of these volumes is irreproachable. The author has had long experience in the teaching of students, and this, in addition to a wide and varied experience of his subject, affords a sufficient guarantee of the trustworthiness of his views.

KIRKE'S PHYSIOLOGY. (a)

OUR old friend, "Kirke's Handbook of Physiology," which has held the student market for at least a quarter of a century to our knowledge, is gradually attaining a pitch of perfection which makes one envy the student of to-day. A work which has attained its sixteenth edition and can boast of some 650 illustrations, some of them being coloured plates, is hardly likely to call for much criticism. As editions roll by, errors are eliminated and disproved theories are replaced by others more in accordance with the latest views. In spite of all that has been accomplished by patient research, much physiological dogma still fails to be more than a "view," liable *qua* view to revision and modification. Never, however, has physiological research been more active, and even during the short period that has elapsed since the preceding edition, many points have been elucidated, and these have been duly incorporated in the present edition. The chapter on the circulation of the blood has been elaborated and extended, thanks largely to the collaboration of Dr. Leonard Hill. The only other change of note is the relegation of the chapter on the central nervous system to the end of the book, no doubt the most suitable place for this, the keystone of physiology.

We cannot forego a word of praise for the typography of the work, for this is exceptionally good. The illustrations, too, are for the most part, finely drawn, and the colour printing of some of them introduces an agreeable element of novelty. The author is to be congratulated on having succeeded in keeping the work well up to date without any material increase in the size of the volume. So far the work is not threatened with the obesity which is so often the forerunner of senility.

NEWMAN'S RENAL CASES. (b)

THIS book consists of a series of cases taken from Dr. Newman's practice illustrating various affections of the kidneys, the account of the cases being accompanied by remarks from the author. It is divided into chapters, all of which will repay perusal, especially the one containing cases of cystic disease of the kidney, with special reference to their pathology, diagnosis and surgical treatment. Dr. Newman has thoroughly gone into the rather nebulous subject of cysts of the kidney, dividing them into four classes: (1) simple cysts and cystic degeneration; (2) congenital cysts; (3) paranephritic cysts; (4) those due to the presence of parasites. The several chapters illustrating hæmaturia from various causes connected with the kidney all carry their lesson, whilst the theories promulgated in the last chapter on renal "Phthisis ab hæmoptoe" are undoubtedly dictated not only by extensive pathological knowledge but also by sound common sense.

LESSONS IN ELEMENTARY PHYSIOLOGY. (c)

OUR familiarity with these lessons dates back almost to childhood. The work was the pioneer of elementary treatises at the time of the great awakening some 35 or 40 years ago when the public became alive to the necessity for a revision of the existing method of education, and the introduction of the scientific element. Teachers and students were not over exacting in those days, and it came to pass that Huxley's Physiology was looked upon almost as a text-book for senior students, although to-day, in its original form, even average students would look askance at it, in spite of the peculiar charm and lucidity which stamp all the written utterances of our regretted master.

The work before us bears but a fallacious likeness to its original. We have the same green covers, the same format, and approximately, the same typography, but we

(a) "Kirke's Handbook of Physiology." By W. D. Halliburton, M.D., F.R.S., Professor of Physiology, King's College. London. 16th Edition. London: John Murray. 1900.

(b) "Renal Cases." By David Newman, M.D. Glasgow: James Maclehose and Sons. P. 151.

(c) "Lessons in Elementary Physiology." By Thomas H. Huxley, LL.D., F.R.S. *enlarged and revised edition. London: Macmillan and Co., Ltd. 1900.

may say of it, as the gentleman said of his father's portrait, painted from memory, "How he has changed since he died." The change, we hasten to say, is all in the direction of improvement, an assurance which is assuredly uncalled for when we recall that the revision, a labour of love, has been carried out by Sir Michael Foster, with the assistance of Dr. Lea.

The author's form of exposition, indeed, as far as possible, his own words, have been preserved, but, of course, it has been found necessary to make considerable changes and additions in order to render the present work worthy of its predecessor, which, in its time, was a trustworthy guide to the elements of physiological science.

In its present form we can safely predict for it a recrudescence of popularity. The phraseology is untechnical enough to allow of its use by science students other than medical, but this by no means militates against its suitability for use by the latter, indeed, Huxley's simplicity of diction gives a charm to details which, in other hands, are singularly unattractive.

NORRIS AND OLIVER ON DISEASES OF THE EYE. (a)

THIS, the fourth volume, completes the magnificent system of ophthalmology produced under the joint editorship of Drs. Norris and Oliver. We have nothing but praise for the work, so far, at least, as the editors and publishers have carried out their respective parts in its production. Of course, the articles in the various volumes are not of equal merit; some are poor, others excellent, and some again do not sufficiently reflect the accredited opinions of authorities upon the subjects with which they deal. Such features, however, are inseparable from a work of the kind. In the volume before us, Dr. Landret commences with a well-written comprehensive account of the "Anomalies of the Motor Apparatus of the Eyes," and Dr. Nuel follows with a chapter on "Diseases of the Cornea." In a chapter of 142 pages, "Diseases of the Lens" is discussed by one of the editors, Dr. Norris. Dr. Oliver, the other editor, writes on "Ametropia," and Dr. Haab on "Ocular Lesions Dependent upon Diseases in the Circulatory System"; Dr. Swanzy on "Eye Diseases and Eye Symptoms in their Relation to Organic Diseases of the Brain and Spinal Cord"; Dr. J. B. Lawford on "Ocular Lesions Dependent upon Disorders of the Secretory and Excretory Organs"; Dr. John B. Story on "Ocular Lesions in Variola, Rubella, Morbilli, Scarlatina, Erysipelas, and Diphtheritis"; Dr. Santos-Fernandez on "The Ocular Lesions of Influenza, Dysentery, Cholera, Malarial Fever, Dengue, and Yellow Fever"; Dr. Parinaud on "The Ocular Manifestations of Hysteria"; Mr. Johnathan Hutchinson, junior, on "Eye Affections due to Graves' Disease and Herpes Zoster"; Dr. Myles Standish on "Motor Changes in the Ocular Apparatus associated with Functional Neuroses"; Dr. Schweinitz on "The Toxic Amblyopia"; Dr. M. Salzmann on "The Entozoa of the Human Eye"; Dr. Baudry on "Simulated Blindness"; and lastly Dr. Gazet on "The Ocular Signs of Death." Thus from the diversity of the subjects dealt with, it will be gathered that the volume is one of exceptional interest. It worthily completes Drs. Norris and Oliver's system, and the work, as a whole, far surpasses in importance and value other standard treatises upon ophthalmology.

KNOFF ON PULMONARY TUBERCULOSIS.

WE are asked to announce that the work which was reviewed under this title in our last issue, can now be obtained in this country of Mr. H. K. Lewis, Publisher, of 136, Gower Street, London.

(a) "System of Diseases of the Eye." By American, British, Dutch, French, German, and Spanish Authors. Edited by William F. Norris, A.M., M.D., and Charles A. Oliver, A.M., M.D. Vol. IV., with 51 full-page plates, and 211 text illustrations. London and Philadelphia: J. B. Lippincott Co. 1900.

Laboratory Notes.

TEUSCH'S NITRO-PROPIOL TEST.

WE have received from Messrs. Wilcox and Co., 40, Haymarket, S.W., a sample of Nitro-Propiol tablets for carrying out Teusch's test for the presence of sugar in the urine. One tablet is dissolved in three fluid drachms of water, to which ten drops of the suspected urine is added, the mixture being then boiled for from three to five minutes. The presence of glucose, even in minute quantities, is at once revealed by an indigo-blue colouration. Although, like most other tests of the kind, the test requires to be interpreted with discrimination, it presents certain advantages, notably its delicacy, the fact that it reacts with glucose only, and its technical convenience. For clinical work in daily practice the portability of the tablets is distinctly a convenience.

TABLOIDS AND SOLOIDS.

AMONG recent additions to the list of "tabloid" preparations we note the effervescent tabloids of Salicylic Acid (grs. 3), introduced as a convenient and agreeable way of administering the drug. Physiologically pure acid is employed in their production.

The latest departure in the treatment of the gouty diathesis is the use of chloride of potassium as a table salt in lieu of the corresponding sodium salt, on the ground that the former (as is well known) forms a more soluble salt with uric acid, thus facilitating its elimination. Acting on this suggestion, Messrs. Burroughs, Wellcome, and Co. put up 20-gr. tabloids of potassium chloride. One of these, crushed into powder at table, furnishes salt enough for use. The idea is ingenious and practical and will no doubt be appreciated.

We need hardly do more than call attention to the existence of tabloids of Guaiacous Resin (grs. 5), the advantages which they offer for the exhibition of a nauseous drug being sufficiently obvious.

Passing on to the *Soloid* department, we note the association of permanganate of potassium (grs. 3) and alum (grs. 5), a combination which, when dissolved, yields a ready-made solution possessing characteristic antiseptic and astringent properties, applicable to a great variety of circumstances.

Among the *soloids* we have to announce further additions to the list of microscopic stains. The last batch comprises indigo - carmine, methyl orange, rosolic acid, phenolphthalein, and starch. The convenience of these accurately-measured agents in preparing solutions of known strength for laboratory work is great, and we should imagine that they will in future be employed to the exclusion of the salts in bulk.

MESSRS. BURROUGHS, WELLCOME AND CO. now put up Protargol, this fashionable anti-gonorrhoeal remedy, in 1-grain and 4-grain "soloids." It is unnecessary here to insist on the astringent, antiseptic and bactericidal properties of the salt, but the ease with which accurately dosed solutions can be made from these tabloids will commend them to the favour of practitioners.

CARNOS.

"CARNOS" is the trade name of a preparation of meat extract prepared by the Carnos Company, of Grimsby. It is a dark, brown fluid with an agreeable odour. When diluted with a suitable quantity of water, hot or cold, it makes a nourishing and palatable beverage. We have tried it as a soup with great success. According to the analysis furnished to us it contains over 22 per cent. of albuminoids, and about 16 per cent. of carbo-hydrates, with, proportionally, large percentages of phosphates and potash salts. It is put up in several forms, among others the "Carnos Flask" for cyclists and travellers, this being provided with a metal cup. This is distinctly a good idea, and assuming the possibility of obtaining a supply of trustworthy water, the parched cyclist could not wish for a more refreshing and sustaining beverage.

Medical News.

Association of Asylum Workers.

THE annual meeting of this society (founded in 1895 to improve the status of Asylum nurses and attendants, to provide for them "Homes of Rest and Nursing," and to enlist public sympathy in their work), will be held in the rooms of the Medical Society of London, 11, Chandos Street, on Monday, May 14th, at 4 p.m., Sir James Crichton-Browne, M.D., LL.D., F.R.S. (President of the Association), in the chair. All interested in Asylum work and workers are cordially invited to attend.

The Neale Testimonial Fund.

THE following subscriptions have been received by Mr. Macalister for this fund. It is proposed to close the list very shortly, and it is, therefore, earnestly hoped that those who intend to subscribe will send in their subscriptions to Mr. J. Y. W. Macalister, 20, Hanover Square, London, without delay. Cheques should be made payable to "Bearer," and crossed "Neale Testimonial a/c, National Provincial Bank."

	£	s.	d.		£	s.	d.
Sir William Turner, F.R.S.	1	1	0	Dr. E. W. Goodall	1	1	0
Dr. E. Wolfenden Collins	1	1	0	Sir Edwin Saunders	1	1	0
Mr. Thomas Bryant	3	3	0	Mr. Herbert Allingham	2	2	0
Dr. Amand Bouth	2	2	0	Dr. J. Abercrombie	1	1	0
Dr. T. Stretch Dowse	3	3	0	Dr. Thomas Buzzard	2	2	0
Mr. W. Nutt Galton	1	1	0	Mr. E. Clement Lucas	1	1	0
Mr. George P. Field	2	2	0	Dr. A. P. Luff	0	10	6
Dr. C. J. Cullingworth	2	2	0	Dr. G. H. Savage	1	1	0
Mr. E. Noble Smith	3	3	0	Dr. Cooper Rose	1	1	0
Dr. T. Clifford Allbutt, F.R.S.	1	1	0	Dr. W. S. Church	1	1	0
Mr. E. F. Cooper	0	10	6	Mr. H. H. Clutton	1	1	0
K.	0	10	0	Lord Lister, P.R.S.	5	0	0
Dr. G. Fielding Blandford	1	1	0	Dr. J. J. Macwhirter Dunbar	1	1	0
Sir T. Lauder Brunton, F.R.S.	5	5	0	Mr. E. Unwin Berry	2	2	0
Mr. R. Fye-Smith	1	1	0	Dr. T. D. Savill	0	10	6
Eliz. Garrett Anderson, M.D. Paris	1	1	0	Dr. Charles Coates	5	5	0
Mr. Christopher Heath	1	1	0	Dr. A. B. Carpenter	1	1	0
Mr. Henry Power	1	1	0	Mr. C. B. Keetley	1	1	0
Dr. Frederick T. Roberts	1	1	0	Mr. Edward Wood	0	10	6
The Bristol Medical Library	1	1	0	Dr. W. B. Cheadle	1	1	0
Sir Douglas Powell, MD	2	2	0	Mr. D'Arcy Power	0	10	6
Mr. Malcolm Morris	1	1	0	Mr. W. Adams Frost	2	2	0
Sir William Broadbent, F.R.S.	5	5	0	Dr. A. Fraser	1	1	0
Dr. F. W. Pavy, F.R.S.	2	2	0	Dr. K. Grube	1	1	0
Mr. A. Pearce Gould	1	1	0	Dr. A. Donald	0	10	6
Mr. Alban Doren	1	1	0	Dr. F. P. Weaver	1	1	0
Dr. Sidney Martin, F.R.S.	1	1	0	Dr. W. Allen Sturge	1	1	0
Sir Thomas Smith	1	1	0	Mr. S. J. Sharkey	1	1	0
Dr. J. Ford Anderson	1	1	0	Dr. E. Clifford Beale	1	1	0
Dr. J. Moorhead	1	1	0	Mr. T. Holmes	1	1	0
Dr. W. P. Herringham	1	1	0	Dr. G. Sims Woodhead	1	1	0
Dr. A. Foxwell	1	1	0	Dr. James Little	2	2	0
Dr. Byrom Bramwell	5	0	0	Mr. G. Anderson Critchett	2	2	0
Dr. Wharton Hood	1	1	0	Mr. W. H. Bennett	2	2	0
Dr. T. F. Chavasse	1	1	0	Dr. P. Horrocks	1	1	0
Mr. Edward Nettleship	1	1	0	Dr. F. de Havilland Hall	1	1	0
				Mr. H. G. Howse	3	3	0
				Dr. H. Fye-Smith, F.R.S.	2	2	0
				Mr. J. Adams Rawlins	0	5	0
				Dr. B. A. Gibbons	1	1	0
				Mr. John Ewens	0	2	6
				Dr. A. Haig	1	1	0

DR. G. R. HARCOURT, Assistant Medical Officer at the Lambeth Infirmary, was the victim, a few days since, of a violent assault at the hands of one of the inmates, who has since been sentenced to a month's imprisonment.

The Medical Sickness and Accident Society.

THE usual monthly meeting of the Executive Committee of the Medical Sickness, Annuity, and Life Assurance Friendly Society was held on the 27th ult., at 429, Strand, London, W.C. There were present Dr. de Havilland Hall, in the chair; Dr. J. B. Ball, Mr. F. S. Edwards, Dr. J. W. Hunt, Dr. Alfred S. Gubb, Mr. William Thomas, Dr. Francis J. Allan, Dr. M. Greenwood, Mr. J. Brindley James, Dr. W. Knowsley Sibley, Mr. Frederick Wallace, Dr. Walter Smith, and Mr. Edward Bartlett. The Committee examined the draft report for the year 1899, to be presented to the members at the general meeting on the 17th inst. It shows that the Society did a successful year's business, the number of members having increased to 1,945

and the funds to over £180,000. The amount paid away in sickness benefit last year was the largest required for the purpose in any twelve months of the society's working, but was within the amount expected and provided for in the tables. The experience of this year is, so far, much more favourable than that of 1899, and the society seems likely to considerably increase its already large reserves during the current twelve months. Prospectuses and all particulars on application to Mr. F. Addiscott, Secretary, Medical Sickness and Accident Society, 33, Chancery Lane, London, W.C.

Royal College of Surgeons, Ireland.

AT a meeting of the President, Vice-President, and Council, held May 1st, the following Examiners were elected—

Examiners in Anatomy—Ambrose E. I. Bermingham, Alexander Fraser.

Examiners in Surgery—H. Gray Croly, William Stoker.

Examiners in Physiology and Histology—Charles Coppinger, J. Alfred Scott.

Examiner in Biology—John J. Burgess.

Examiner in Pathology and Bacteriology—Arthur Hamilton White.

Examiner in Pathology—Joseph D. M'Feely.

Examiner in Midwifery and Gynaecology—Frederick W. Kidd.

Examiners in Ophthalmology—Arthur H. Benson, Louis Werner.

Examiner in Sanitary Law and Vital Statistics—James H. Fergusson.

Examiner in Engineering and Architecture—J. Charles Wilmot.

Examiners in Dental Surgery and Pathology—Arthur W. W. Baker, Daniel Corbett.

Examiners in Mechanical Dentistry—George M. P. Murray, William Booth Pearall.

Examiners in Chemistry and Physics—Edwin Lapper, Robert J. Montgomery.

Examiner in Languages—L. J. Woodroffe.

Examiner in Mathematics, Physics, Dictation, and English Essay—J. W. Tristram.

The Royal University of Ireland.

THE Senate of the Royal University of Ireland met on May 3rd. There were present:—Dr. Allman, F.R.S. in the chair; Rev. Dr. Delany, Judge Shaw, Sir Christopher Nison, Mr. Cumming, Rev. Dr. Hamilton, Dr. Leeboddy, Sir Henry Bellingham, Bart., and Sir James Creed Meredith and Dr. Joseph McGrath, secretaries. The recommendations of the Standing Committee upon the results of the recent Spring Medical Examinations were considered and approved. The death of Professor Thomas Preston, D.Sc., F.R.S., one of the Fellows of the University, having been reported, a resolution expressing regret at the loss which the University had sustained, and urging the claims of Professor Preston's family for a Civil List pension, was unanimously adopted.

A resolution of regret and sympathy on the death of Mr. John E. Oram, M.E., the Librarian and Chief Clerk of the University, was passed unanimously. The vacancies consequent on Mr. Oram's death were filled by promotions in the office.

PASS LISTS.

Dublin Conjoint Examinations.

The following have passed the Third Professional Examination:—

(a) In All Subjects: C. E. Boyce, J. F. Brogan, G. Downing, J. Dundon, J. L. Gilmartin, J. S. Lane, H. S. Maxwell, A. A. W. Merrick, T. J. Tallon.

(b) Completed Examination: G. F. Alderdice, J. F. Allen, A. T. Benson, E. A. Campbell, W. H. Dodd, A. D. Dunwoody, C. H. Falvey, D. A. Faris, T. S. G. Martin, J. O'Leary, E. M. Pennelather, T. N. Smith, A. B. Stephenson, E. R. Townsend.

(c) In Medicine: E. Allison, S. Browne, E. Duffy, M. Graham, J. F. Peart, A. L. Tyndall.

(d) In Surgery: V. F. Connor, J. F. Peart.

(e) In Pathology: E. Allison, J. R. Magee.

(f) In Therapeutics: E. Allison, M. Graham, J. F. Peart.

(g) In Forensic Medicine, &c.: E. Allison, H. M. Clarke, M. Graham, J. R. Magee, J. F. Peart.

(h) Anatomy: T. Studley.

Notices to Correspondents, Short Letters, &c.

CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

A GLASGOW STUDENT.—1. Rose and Carless's Manual of Surgery. 2. Taylor's Medicine. 3. Stewart's Manual of Physiology. 4. Bevan Lewis or Campbell Clark's Mental Diseases.

YORKSHIRE.—We understand that the *Sanitary Record* is organising excursions to the Paris Exhibition for medical men and others engaged in sanitary work, at exceptionally cheap inclusive rates. You will see a brief reference on page 440 MEDICAL PRESS and CIRCULAR, April 25th.

Mr. J. W. S.—We have no objection to your making use of our article provided it is suitably acknowledged.

THE WAR AND THE WOUNDED.

We are asked by the proprietor of the well-known Bitters Park Hotel, Homburg, to announce that he has made special arrangements for sick and wounded officers and their wives staying at his hotel, allowing them a discount of 25 per cent. from regular and pension terms.

THE DISCOVERER OF THE "SERUM AGGLUTINATION TEST."

The statement contained in our last issue that the credit for the discovery of the serum agglutination phenomenon (commonly known as Widal's reaction), was due to 'Professor Grunbaum, of Vienna' was an obvious error, Dr. A. S. F. Grunbaum being assistant lecturer on physiology at the Liverpool School of Medicine.

Meetings of the Societies and Lectures.

THURSDAY, MAY 10TH.

BRITISH GYNÆCOLOGICAL SOCIETY (20, Hanover-Square, W.)—Specimens will be shown by Dr. W. Walter, Dr. W. Ramsay, Dr. A. Giles, Mr. F. Edge, and Mr. F. Jordan. Papers:—Dr. H. Snow: Notes of Two Cases of Vagino-rectal Excision for Cancer.—Mr. R. Morrison: Some New Methods of Pelvic Operations in the Female.

NEUROLOGICAL SOCIETY OF LONDON (11, Chandos Street, W.)—8.30 p.m. Pathological Evening. Dr. W. Barrett: Subdural Blood Cyst.—Dr. F. E. Batten: Cyst in Seventh Post-spinal Ganglion associated with Subcutaneous Hemorrhages following Distribution of the Root.—Dr. Taylor: Changes in the Cells of the Third and Sixth Nuclei from a case of Ophthalmoplegia Externa. And other Specimens.

FRIDAY, MAY 11TH.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.)—8.30 p.m. Papers:—Dr. F. E. Batten and Dr. Prickett: A case of Acute Encephalitis in a Child following Influenza.—Mr. Battle: Three Cases of Cholelithotomy.—Mr. Bland-Sutton: On a Case in which a Gall-stone impacted in the Duodenal Orifice of the Common Bile Duct was extracted through an incision in the Bowel, Recovery.—Dr. Parkes Weber: Pneumothorax without Effusion in an apparently healthy man.

BRITISH LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL ASSOCIATION (11, Chandos Street, Cavendish Square, W.)—8.30 p.m. Demonstration:—Dr. Macintyre (Glasgow): On the Use of X-rays in Diseases of the Upper Respiratory Tract.

ROYAL ACADEMY OF MEDICINE IN IRELAND.—Section of Surgery, May 11th. 8 p.m. (1) Mr. J. F. Knott on Dupuytren's Contraction of the Palmar Fascia. (2) Mr. E. H. Taylor on the Operative Treatment of Cleft Palate. (3) Mr. F. Heuston on a Case of Cystic Sarcoma of Kidney treated by Nephrectomy.—Living Specimens: Mr. H. G. Croly (4) Radical Cure of Femoral Hernia by Displacement method, two cases. (5) Adult Ma's whose Extensor Tendons of Right Hand were Sutured and finger movements restored. (6) Soldier Shot in side and through Popliteal Space with Skiagram. 2. Mr. R. F. Tobin (4) Excision of Knee, operated on April 16th. (5) Excision of Elbow. 3. Mr. John Lentaigne (4) Boy on whom Laparotomy has been twice performed for Intestinal Obstruction caused by large Coproliths. (5) Excision of Elbow Joint. 4. Mr. R. L. Swan: Patient from whom large Dermoid Tumours of Neck had been removed.—Card Specimens: 1. Mr. R. F. Tobin (a) Splint for Treatment of Fracture in neighbourhood of Shoulder Joint. (b) Splint for Treatment of Fracture in neighbourhood of Knee or of Hip Joint. 2. Mr. John Lentaigne (4) Coproliths causing Intestinal Obstruction removed by Laparotomy. (5) Specimen showing Fracture of Olecranon, head of Radius and Capitulum removed by Excision of Elbow Joint. 3. Mr. R. L. Swan: Dermoid Tumour of Neck. 4. Mr. Kelly (Ennisworthy) Instrument for necessary Cases of Hernia for Trusses.

Appointments.

ARMSTRONG, J., L.R.C.P., L.R.C.S., Certifying Surgeon under the Factory Acts for the Ballymahon Dispensary District, Longford.

BUCHAN, A. HALL, M.A., M.B., C.M., M.R.C.S.Ed., an Assistant Physician to the Leith Hospital.

COTMAN, H. H., L.S.A., House Physician to the Seamen's Hospital, Greenwich.

EASON, JOHN, M.B., C.M., M.R.C.P.Ed., an Assistant Physician and Registrar to the Leith Hospital.

EDDISON, F. R., M.R.C.S., L.R.C.P.Lond., Senior Resident Medical Officer to the Royal Free Hospital, London.

FLYNN, E. F., L.R.C.P., L.R.C.S., Certifying Surgeon under the Factory Acts for Dungarvan, county Waterford.

HADFIELD, P. HEYWOOD, M.A., L.R.C.S. and P.Ed., L.F.P. and S. Glasg., Senior House Surgeon at the Stanley Hospital, Liverpool.

HAMILTON, GRAEME, M.B., Ch.B. Edin., Senior House Surgeon to the Children's Infirmary, Liverpool.

MEREDITH, R. W. H., M.R.C.S., L.R.C.P., House Surgeon to the Seamen's Hospital, Greenwich.

Vacancies.

City Asylum, Nottingham.—Second Assistant Medical Officer, unmarried. Salary £150, with board, apartments, and washing.

City of Glasgow Fever Hospital.—Physician Superintendent at the Belvedere Hospital. Salary £400 per annum, with house accommodation, board, and attendance. Applications to Mr. J. Lindsay, City Chambers, Glasgow.

Clayton Hospital and Wakefield General Dispensary, Wakefield.—Senior House Surgeon, unmarried. Salary £150 per annum, with board, lodging, and washing.

County Asylum, Rainhill, near Liverpool.—Assistant Medical Officer to act as Locum Tenens for about four months during the summer. Salary £3 3s. per week, with furnished apartments and board.

Cumberland and Westmorland Asylum, Garlands, Carlisle.—Junior Assistant Medical Officer, unmarried. Salary £130 a year, rising to £150, with board, residence &c.

Great Northern Central Hospital.—House Physician for six months. Salary at the rate of £60 per annum. Also a Junior House Phys. Salary at the rate of £30 per annum, with board, lodging, and washing provided in both cases. Applications accompanied by testimonials to be addressed to Lewis H. Glenton-Kerr, Esq., at the hospital. (See advt.)

Durham County Asylum, Winterton, Ferryhill.—Second Assistant Medical Officer. Salary £170 per annum, rising £10 annually, to £220, with rooms, board, laundry and attendance.

Elenties Rural District.—Medical Officer. Salary £100 per annum, with the usual vaccination fees. Immediate application to Michael Inchelis, Union Clerk. (See advt.)

Gateshead Union.—Assistant Resident Medical Officer for the Workhouse. Salary £150, with apartments, rations and washing. Applications to the Clerk, Union Offices.

Manchester Children's Hospital, Pendlebury.—Medical Officer for the Dispensary of the above Institution. Salary £180 per annum. Applications to the Secretary, Manchester.

Middlesex Hospital, W.—Dental Surgeon.

Nottingham General Dispensary.—Assistant Resident Surgeon, unmarried. Salary £140 per annum, all found, except board.

Royal Devon and Exeter Hospital, Exeter.—Assistant House Surgeon for six months. Salary at the rate of £100 per annum, with board, lodging, and washing.

Surrey County Asylum, Brookwood, near Woking.—Third Assistant Medical Officer, unmarried. Salary £120, rising £10 annually to £150, with board, lodging attendance, and laundry.

Three Counties Asylum, near Hitchin.—Second Assistant Medical Officer, unmarried. Salary commencing at £150 per annum, with board, apartments, washing, and attendance

Births.

GARLAND.—April 26th, at 26, Arran Quay, the wife of Dr. Garland, of a son.

LEICESTER.—On May 2nd at the residence of her brother-in-law, 42, Minto Street, Edinburgh, the wife of Merton E. Leicester, M.D., of a daughter.

McWEENEY.—April 26, at 84, St. Stephen's Green, the wife of E. J. McWeeny, M.D., of a daughter.

Marriages.

COLBY—BRYANT.—On May 1st at St. Mark's Church, Surbiton, Francis E. A. Colby, M.B., F.R.C.S., third son of W. Taylor Colby, M.D., of Malton, Yorkshire, to Elsie, elder daughter of the late Arthur Charles Bryant, and Mrs. A. C. Bryant, of Oak Hill Lodge, Surbiton.

EDWARDS—HILL.—On May 2nd at the Parish Church, Ludlow, Lewis Charles Edwards, M.B., son of the Rev. T. C. Edwards, Principal of University College, North Wales, to Lillian, daughter of E. C. Hill, Esq., of Newcastle, Staffs.

FINLEY—McKELVIE.—On April 25th, at St. John's Church, Hensingham, Harry Finley, M.D. Lond., of West Malvern, only son of H. T. E. Finley, of Wimborne Minster, Dorset, to Lillian, elder daughter of the late John McKelvie, of Whitehaven.

WOODFORD—THORNE.—On May 2nd at Holy Trinity Church, Gray's Inn Road, by the Rev. F. Thorne, father of the bride, and Rev. A. J. Woodforde, father of the bridegroom, Robert E. H. Woodforde, M.R.C.S., L.R.C.P., of Ashwell, Herts, to Mary T. Thorne.

Deaths.

BIRD.—On the 4th, at 6, Windmill Hill, Hampstead, George Bird, M.D., late of 49, Welbeck Street, London, in his 83rd year.

CLARKE.—On April 23rd, at 150, New Hall Lane, Preston, of pneumonia, after a short illness, J. K. Clarke, M.R.C.S., L.R.C.P.

CARTE.—At Lagos, West Africa, Surgeon-Major William Alexander Carte (late Grenadier Guards), eldest son of the late Dr. Carte, J.P., Royal Hospital, aged 43 years. (By cable.)

NEWMAN.—On April 23rd, at St. Martin's, Bowness, Windermere, Anthony John Newman, L.R.C.P.Ed., M.R.C.S., aged 59.

SMITH.—On April 9th on board the s.s. *Canara* off the coast of Belovochistan, Hugh Victor Smith, M.R.C.S., L.R.C.P. (buried at sea), aged 26.

WIBLIN.—On April 27th, at Northleigh, Wimborne Minster, Dorset, John Wiblin, F.R.C.S. Eng., aged 86.

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No. 20.

Paris Clinical Lectures. THE RELATIONSHIP OF DIABETES MELLITUS TO EPILEPSY.

By PROFESSOR W. EBSTEIN,

Lecturer on Diseases of Special Organs and Therapeutics at the Medical Faculty of Göttingen.

CONTRARY to what one would expect diabetes or even glycosuria is a very rare complication of epilepsy. Delasiauve, for instance, states that neither he nor Michéa have ever discovered any sugar in the urine of epileptic subjects, Reynoso's assertion to the contrary notwithstanding. This is rather surprising, considering that diabetes, epilepsy, and mental disease are frequently met with alternately among the various members of families in which there is an hereditary neuropathic taint. On the other hand, those who, in opposition to Reynolds, maintain that true epilepsy is associated with anatomical lesions, do not mention glycosuria in connection with epilepsy. The consensus of opinion seems to be that there is no constant type of pathological changes in the urine of epileptic patients.

There are three possible relationships between diabetes mellitus and epilepsy: the glycosuria may be either the cause or the effect of the epilepsy, or both conditions may arise independently of each other, though due to a common cause.

Cases in which diabetes is the cause of epileptic or epileptoid attacks may further be divided into two distinct categories, according as these attacks are attributable to the cerebral lesions sometimes observed in the course of diabetes, or simply to some disturbance in metabolism consecutive to the glycosuria.

Cases belonging to the former group do not appear to be of frequent occurrence. Lépine and Blanc have reported one case of this kind in a labourer, 39 years of age, who at the onset of the disease eliminated as much as a kilogramme of sugar in the urine in the twenty-four hours. The glycosuria then gradually decreased and ultimately disappeared entirely a short time before death. This patient, who died from pulmonary tuberculosis, had presented right hemiplegia, epileptic seizures, aphasia and dementia with paroxysms of nocturnal excitement, all these symptoms ceasing at a given moment. At the autopsy there were obvious lesions of the psychomotor centres.

In the second group of cases of epilepsy due to diabetes, the convulsive spasms are determined by toxic products of the intra-organic exchanges, and affect more or less the form of coma. Finlayson has described a case of this kind in a man, 34 years of age, suffering for nine months from grave diabetes,

who seventeen hours before death, developed convulsive attacks alternating with furious mania. The urine contained no albumen; the ferric chloride test gave a negative result. The autopsy threw no light on the condition. In connection with this case, Finlayson mentions that, of 16 cases of diabetic coma under Dreschfeld's observation, convulsions were present only in one, and that among 80 other cases collected by the same observer, convulsive attacks were met with only in six.

G. W. Jacoby has recently reported three cases of diabetic epilepsy, an affection which he looks upon as due to acetonæmia, and consequently of toxic origin, just as in alcoholic or plumbic epilepsy. This (acetonæmic) diabetic epilepsy is said to be very rarely met with, because in the majority of cases acetonæmia runs an acute course, leading to fatal coma. When acetonæmia develops in a chronic and intermittent manner, it determines, according to Jacoby, epileptic seizures, Finlayson's and Dreschfeld's observations, however, show that, on the contrary, intermittent acetonæmia is not the only cause of convulsive attacks.

Among cases in which diabetes appears to be dependent upon epilepsy, there are also two clinical varieties, viz.: those in which the elimination of sugar merely follows each convulsive attack, and those in which glycosuria is a more or less constant accessory symptom of the epilepsy.

Glycosuria consecutive to epileptic seizures has often been looked for, and certain older observers have claimed to have obtained evidence of the existence of such a sequel of epilepsy. For my own part, I have never found any sugar in the urine passed after epileptic fits, and the same is true of Huppert. It appears from all that has been published so far on this subject, that epileptic attacks as a rule are not followed by glycosuria.

The appearance of confirmed diabetes in the course of epilepsy is very difficult to control, inasmuch as it is, of course, frequently impossible to prove that, in such cases, the diabetes is really consecutive to the epilepsy. On the other hand, the coexistence of these two affections may be merely a coincidence, a conclusion at which Griesinger arrived in a case under his observation. The patient, 23 years of age, had suffered from epileptoid attacks up to the age of 16 years; he then developed diabetes, after having been at work in a sugar refinery for two years. Griesinger did not even suggest the possibility of a relationship of cause and effect between the diabetes and the epilepsy in this case, attributing the diabetes simply to an immoderate use of sugar, although the patient stoutly denied the truth of this allegation. In this connection, the author states that he has in vain searched for sugar in the urine of epileptic patients.

To this class of cases belongs possibly also an observation by Burlureaux, of a lady who had been epileptic for a number of years and suffered from intermittent diabetes.

Be this as it may, as far as I can make out from

the literature on this subject within my reach, no proof has as yet been furnished of epilepsy determining diabetes, or even serving as a predisposing cause.

The third class of cases, those in which diabetes and epilepsy make their appearance simultaneously, also presents two distinct morbid varieties.

In the first place, as has already been pointed out, epilepsy frequently alternates with diabetes and mental disorders in neuropathic families. It would therefore not be in the least surprising if an individual affected with hereditary neuropathy developed simultaneously epilepsy and diabetes, though I have not as yet myself met with a case of this description, or found any mention of one in medical literature.

Lastly, in a subject free from any hereditary neuropathic taint, there may be many predisposing causes determining simultaneously diabetes and epilepsy. I have recently had a case in my Clinique, which appears to belong to this variety.

The patient in this case was a young girl, *æt.* 21, without any history of morbid heredity, who, about two years previously, had an apoplectiform attack with right hemiplegia, aphasia, and pollakiuria. Within a fortnight the paralytic symptoms improved to such an extent that the patient was enabled to resume work as a servant, although she suffered from frequent attacks of headache and dull pain in the limbs which had been hemiplegic. Four or five months after this stroke she began to have convulsive attacks, supervening about once every three weeks and limited to the right half of the body, which were associated with loss of consciousness and biting of the tongue, and were followed by severe headache and a considerable degree of prostration.

On examination, the patient was pale and apathetic, in a condition indicating under-nutrition. There was slight paresis of the lower branch of the right facial nerve. The tongue, which was not deviated, presented traces of having been frequently bitten. The knee-jerk was absent on both sides. The muscular strength of the limbs was considerably reduced on the right side of the body. The corresponding hand was covered with numerous warts, which the patient claimed to have developed after the apoplectiform attack. There was no evidence of emaciation in the limbs on this side. Over the apex of the right lung there was a dull area, extending to the third rib, and auscultation revealed in this region, behind and above, symptoms of bronchial catarrh. The area of cardiac dullness was slightly increased towards the right and left. Over the apex of the heart there was a præstolic murmur, decreasing in intensity in the direction of the large vessels. In the auscultation area of the pulmonary artery there was a distinct diastolic creaking sound. Lastly, the patient complained of a frequent desire to pass water, ill-defined pain in the limbs of the right side and attacks, of generalised headache. During the four months the patient remained at the Clinique, she had three convulsive attacks.

The first, which lasted five minutes, was confined principally to the extremities of the right side, and was followed by contraction of these limbs in flexion. During the attack consciousness and the pupillary reflex were completely abolished, and after it had passed the patient suffered from severe headache.

The second attack occurred while she was walking. She suddenly lost consciousness and fell, her limbs presenting spasmodic movements. When the patient came to she complained, as after the first attack, of excruciating headache. On the left margin of the tongue there was evidence of a recent bite.

At the time of the third attack, the patient after having given vent to three loud shrieks, was seized with convulsive movements of the head, right half of the face and right lower limb. She became cyanosed and

frothed at the mouth. The attack lasted ten minutes, with complete loss of consciousness. This time the tongue was not bitten, but the headache persisted longer than after either of the two previous attacks.

As I have already stated, the patient experienced a frequent desire to micturate. This was simply pollakiuria, and not polyuria, inasmuch as the quantity of urine passed in the twenty-four hours varied between 800 and 1,900 cubic centimetres, the average during forty-seven days having been 980 cubic centimetres daily.

Chemical analysis of the urine quite frequently (eighteen times in forty-seven days) gave evidence of the presence of sugar, but the convulsive attacks exerted no influence on the quantity of sugar in the urine. The amount of glucose which was measured sometimes by means of Fehling's solution, at other times by the polarimetric method, varied between 1·7 and 8·8 grammes in the twenty-four hours. The amount of urea oscillated between 18·99 and 32·4 grammes per day. The potassium ferrocyanide and acetic acid tests sometimes revealed a trace of albumen in the form of a slight opalescence. Lastly, at each microscopical examination, a few hyaline casts were found in the urinary sediment. Ophthalmoscopic examination gave a negative result.

While the patient was at the Clinique her condition improved, as evidenced by better appetite and consequent gain in weight, especially after she had been cured of obstinate constipation, from which she had before been suffering. The physical, pulmonary, and cardiac symptoms persisted as before.

As an explanation of the clinical phenomenon observed in this case, I consider the following theory as the most plausible. The apoplectic stroke resulted from ischæmia of the left hemisphere of the brain, due to the cardiac lesion; this stroke determined right hemiplegia with aphasia, associated with pollakiuria. It is impossible to determine whether the patient had become diabetic already at this time, as the pollakiuria appears to indicate. At any rate, she neither then nor subsequently presented either polydipsia, polyphagia, or polyuria. Some months later the epileptic seizures made their first appearance. In certain of their characters, such as sudden, complete loss of consciousness, biting of the tongue, and disappearance of pupillary reaction, these attacks resembled true epilepsy, whereas in other respects, more particularly the localisation of the convulsions in the half of the body previously affected with paralysis, as well as the existence of pain in this region, they are more closely allied to cortical or Jacksonian epilepsy.

Be this as it may, the co-existence in this case of epilepsy and diabetes—in the form of intermittent diabetes mellitus *decipiens*—is a very remarkable circumstance.

CASES SELECTED FROM THE PRACTICE OF THE WESTERN SKIN HOSPITAL.

By TOM ROBINSON, M.D.,

Physician to the Hospital.

"ALOPECIA AREATA."

A YOUNG woman, *æt.* 21, presented herself on January 6th, with the following history:—

I have had a bald spot on my skull for three weeks; it came quite suddenly and without any itching or other symptom. I am the only member of my family with a similar condition. I never had ringworm or any other skin disease.

On examination there was found in that position where premature baldness first occurs,

a patch which, with the exception of a few stubby and nibbled hairs, was bald. The hairs adjacent to the bald patch were easily extracted. She was ordered to wash the scalp with spirit of soap every other day, to cut the hair muscians' length, and to rub in twice a day with a piece of flannel, recent sulphurous acid. The case was seen at intervals until May 1st, when the following note was made: The hair has grown over the bald area, it is much lighter in colour and finer in texture than the natural hair.

Remarks.—The above case is common in our practice, and is an example of parasitic alopecia areata; it is somewhat unusual in the appearance of nibbled hairs, hairs precisely similar to those seen in the ringworm of children. It would be an error to group all the cases of bald areas on the scalp as alopecia areata, because there are two other examples which are somewhat like them as to external appearances, both of which are absolutely incurable—one in which the bald places are symmetrical and attack the whole hair system (*Alopecia universalis*); the other, in which the bald areas are really scars, which scars are depressed, and feel and look like white china.

SEBORRHOEA OF THE SCALP.

A girl, æt. 17, presented herself in November, 1898, with the following narrative:—

Since I was 11 years of age I have had a scaly head, so much so, that when I brush my hair, scales tumble on to the floor, my hair falls out, and is getting dull and scanty.

Inspection.—The scalp is practically covered by chalky white scales which are heaped up in some situations until the heap is quite an inch above the level of the skin. If the scales are scratched off, the scalp beneath looks red, but does not weep or bleed. There are several well-defined patches on the shoulders, and some on the face; patches which, in some instances, are raised and red; in others depressed, with frilled edges. She was ordered to dab the scalp twice daily with a lotion of sulphurous acid and glycerine, and to wash the scalp twice a week with common yellow soap. The case made rapid improvement, and was discharged as cured six weeks after treatment commenced.

Remarks.—The above case came under my observation soon enough to be cured before any marked deterioration of hair took place. It will be found in practice that nearly all cases of premature and many of senile baldness are preceded by seborrhoea of the scalp. Recent observation has proved conclusively that seborrhoea is a parasitic malady, and owing to this fact, we believe, is due the striking curative value of sulphurous acid. The cases of seborrhoea which do not improve with acid are those in which the epithelial scales are mingled with the fat of the body: in these instances the secretion can be scraped off the scalp like butter.

"COACHMAN'S FACE."

J. T., a woman, æt. 39, presented herself because she had a red face. She told us that her father's was a similar colour.

Status Præsens.—The cheeks, nose, and chin are highly coloured, and when this colour is closely examined it is found to consist of dilated capillaries. These can be seen running irregularly over the cutaneous area. There is neither papular nor follicular trouble, and the skin is unusually soft and elastic. The general health is good. My colleague, Dr. Robert J. Carter, was good enough to show me a similar case which he had treated by means of cutting across the vessels with a many-bladed knife, and certainly there was an improvement. We shall, I think, find that cases where practically the whole face is covered by these dilated capillaries are, as a

rule, best left alone. At times our patients come to us with dilated vessels limited to the nose. In these cases we shall often be able in two or three sittings to diminish the disfigurement by the means which Dr. Carter advocates.

THE

PHYSICAL BASIS OF MEMORY. (a)

By WILLIAM ELDER, M.D., F.R.C.P.ED.,

Physician to Leith Hospital; Author of "Aphasia and the Cerebral Speech Mechanism."

SIR WILLIAM HAMILTON says "that memory, strictly so denominated, is the power of retaining knowledge in the mind, but out of consciousness. I say retaining knowledge in the mind, but out of consciousness, because bringing the *retentum* out of memory into consciousness is the function of a totally different faculty—recollection."

For our purpose it will be much more convenient to use the word memory in a more general sense than that implied in the definition of Hamilton, or in the sense of being equivalent to recollection. We will rather consider that Hamilton's idea of memory is only a part of our more general conception of memory, and that in that conception we also include his faculty of recollection. We would therefore include in our conception of memory, the three acts which, according to Ribot (b), memory includes, viz.:—

- (1) The preservation of certain states.
- (2) Their reproduction.
- (3) Their recognition.

Our conception of the physical changes and processes concerned in the manifestation of consciousness, and in the higher psychical states, is still so imperfect that if we limited ourselves to a consideration of those processes alone, we should get very little light thrown on our subject. But if, as I believe, the same principle of action holds in the higher parts of the nervous system, still so imperfectly understood, as exists in the lower parts of the nervous system, now more perfectly understood, we shall be able to get a better idea of the physical basis of memory. As Ferrier (c) states: "We have no proof of subjectivity or modifications of consciousness apart from the action of the cerebral hemispheres. But we have no reason to believe that anything is superadded, or that the action of the cortical centres is of a different order from that of the most simple nervous apparatus, but rather, that between the simplest reflex action and the most complex cerebral process, there is a continuous unbroken gradation. Why consciousness should arise only in co-relation with the activity of the cerebral hemispheres is a question which has not yet received any satisfactory answer."

Believing, therefore, that memory may be conscious, and sub-conscious, or automatic, let us now consider the physical basis of which memory is a manifestation. After describing nerve cells and nerve fibres, and pointing out that there were nerve centres in the cortex of the brain, some of which were sensory or receptive, and some motor or productive in function, the lecturer described how it was possible to have a nerve impulse which was at first sensory reflected into the motor path and becomes motor in function, and that this reflection could take place at various levels in the nervous system. He then said:—On this depends the principle of what is called reflex action, the simplest form of which may be illustrated by a nerve cell, with an incoming sensory fibre and an outgoing motor fibre. But probably the arrangement is more complicated than this, as in most cases both a motor and a sensory cell are placed in the nerve arc, so that impulses passing along the sensory nerve to the sensory cell are reflected to the motor cell, and along the motor nerve.

The spinal cord by this means is enabled to act to a

(a) Abstract of a Lecture delivered before the Edinburgh Branch of the British Child-Study Association and the Eastern Secondary Teachers' Association. (Published by Oliver and Boyd, Edinburgh.)

(b) Ribot—"Maladies de la Mémoire."

(c) Ferrier—"Functions of the Brain," p. 424.

limited extent in a reflex manner independently of the brain, and many of the organic functions of the body are carried on reflexly. Even in the performance of these reflex actions, one has to suppose the reproduction in the motor and sensory cells of a molecular condition, which had previously occurred at a previous action of the same cells. Here, therefore, we have a memory of a previous action, which makes it possible for another similar action to take place. The power of performing reflex actions by the spinal cord is so well-known, however, that I need not enter fully into the matter. I only mention it to indicate that the sensory path communicates at various levels with the motor path, and that such communications enable the nervous system to act in a reflex manner and sub-consciously.

Bearing in mind this principle of reflex action of the spinal cord, let us pass to the cortex of the brain, where are situated the nerve centres, which are the terminations of the sensory fibres, and the beginning of the motor fibres. We find that the centres are constructed on the same principle. They are more complicated, however, the chief difference in the cerebral cortex being, probably, in the much greater number of collateral branches from the cells, bringing the cells of one centre, not only into intimate communication with the cells of the same centre, but with the cells of other centres on the same level, and with cells on a higher level in the nervous system. In fact, we have in the cerebral cortex an enormous number of nerve cells, having communications with each other of an extremely intricate and complex kind, and so making it possible for nerve impulses to pass in an enormous number of different ways when such impulses reach the cerebral cortex. This, as will be seen, makes it possible for one sensory impulse to be associated with another or with others either sensory, motor, or more truly psychical.

We have, therefore, very intimate associations between the different sensory centres in the cortex, which are called the perceptive centres, and this it is which makes it possible for us to have a full conception of whatever is brought into relation with our sensory organs.

But even these intimate associations of the cerebral cells would be of very little use to us, if it were not for the faculty of memory. For of what good to us would be the nervous impulse, bringing to our visual centres the news that an orange had a certain colour and a certain shape, if the next second that impulse was gone for ever. When next an orange was placed before our eyes we might again get the information which would again be news to us, that an orange has a certain colour and a certain shape, but without memory the sensory impulse would only be for the present. Without memory we would have no past, no past sensations, no past actions, no past thoughts, nor for us could there be anticipation of the future. All would be "present"; our lives, our experiences would be separate entities, having no initial cause and no effect. But happily we have memory, and instead of our lives being made up of separate units of sensations and actions, each having no connection with those going before, and no connection with those coming after, they are made up of sensations and actions, the one following gradually after the other, and each leaving a residue, or *retentum*, which it is possible to recall in various ways at some future time.

Let us investigate still further this power of storing up, and let us take the concrete example of an orange as illustration.

An orange is placed before the eyes of a child for the first time. The visual image of that orange falls on the child retina, and nerve impulses are conveyed along the optic nerves to the visual perceptive centres in the brain. These nerve impulses produce a certain psychical effect, and is interpreted by the child in a particular way. If the child has not seen the colour of an orange before, and if he has not seen that particular shape before, both are quite strange to him—they will recall no previous memories in his mind. But suppose the same or a similar orange is at a later date placed before his eyes, a similar nervous impulse passes up to the visual perceptive centres in the brain, and the child probably is able to recognise that the same of a similar object is placed before his eyes. Suppose the same experiment is

repeated later, the child will probably more readily recognise the object, and not only will he recognise the object, but he may also recall the circumstances which we say were associated with the previous display of the orange, and the oftener he sees the orange, the more readily he recognises it. Suppose at the first time he saw the orange he was allowed to taste it. In that case, a nervous impulse would pass through his nerves of taste to the gustatory centres in the brain, and the resulting gustatory sensation to the child would be a new one. As this sensation is experienced at or about the same time as the visual sensations of the appearance of the orange, when the orange is seen the second time, the child will probably remember the taste. If he smelled the odour of the orange on the first occasion, probably on the second or on future occasions, he would recall its odour when the orange was presented to his sight. Similarly if he were allowed to handle the orange on the first occasion, he would recall the sensation he experienced by his muscular sense and common sensation (hardness, weight, shape, &c.) on future occasions when it was placed before his eyes. After seeing, tasting, smelling, and handling an orange on several occasions, he will have a pretty fair conception of an orange, but he may not yet know its name. If, however, on the orange being shown to him on one or more occasions, the word "orange" is pronounced in his hearing, in all probability the same word-sound "orange" will come up in his memory, when the orange is placed before his eyes in the future.

In this way the sensory impressions of one centre are apt to be associated with the sensory impressions of another centre, and it is in all probability by means of the collateral communications or associating fibres which convey the nerve impulses from one cell to the other, as I have previously mentioned, that this is brought about.

It is supposed that the passage of a nerve impulse along a particular route makes it easier for a similar impulse to pass along the same route on a future occasion, and so the oftener similar sensations are experienced the more readily are their associations recalled.

This association depends on a law which has been stated in various ways, but which may be shortly stated thus:—When two sensations are experienced at or about the same time, the recall of one of these sensations at a future time is apt to be accompanied or followed by the memory of other sensations. When sub-conscious, it may be called a law of organic suggestion, and holds good for the motor or productive system, as well as the sensory. By this law each member of a series of sensations or acts suggests the following sensation or act. There are many examples which might be taken in illustration of this. All of you know that we can do many things without thinking what we are doing—even long complicated acts, such as walking whilst thinking about all sorts of things. The complicated nervous process involved in walking goes on automatically or sub-consciously in a regular manner. A more complicated series of actions than the mere walking is the walking up a staircase with a series of landings. If one knows the stair, that is, has gone up frequently, it is quite possible to go up without thinking about the stair at all. Or take the act of soldiers on march and asleep, or take the still more complicated act cited by Carpenter of the pianist playing whilst asleep. In each of these cases, all that is necessary is to begin the action, and the other nervous processes follow in their order.

But the memory of previous sensations experienced can be roused in another way, viz., from above, that is what we call voluntarily. A person can recall past experiences; he can voluntarily rouse the memory of past sensations. In other words he can recollect by an act of will. I do not pause to ask here what constitutes will, or how such a psychical state results that the individual wills to do a thing or whether such a state usually or always results from the reaction of the individual to his surroundings. In other words, whether such "will" is always the result also of sensations. Much can be said for this view, but I wish to point out here that probably there are higher centres in the brain than these sensory and motor centres. From these higher centres we have nervous impulses passing to the

sensory centres and there rousing the memories of past sensations and their associated sensations. Taking our concrete example of the child and the orange, the child may at any time recall the memory of the appearance of the orange, of its colour, of its taste, of its smell, and of the other characters including its name. I do not inquire how a child is set a-thinking about the orange at all, and why it wills to recall the memory of an orange. The causes of the lines in which thought is directed are obscure, but probably such lines even of abstract thought are chiefly directed by present sensations and the memories of previous sensations, in other words, the reaction of the individual's nervous system to his surroundings.

After giving examples of how thoughts may arise from the memory of old sensations being roused either consciously or sub-consciously, the lecturer went on.

There are certain conditions necessary in order that a person may retain the memory of a sensation or action. It is necessary in the first place that the impression should be of sufficient duration and of sufficient intensity to fix it in the memory. As you all know, in popular language, a thing may go in at one ear and out at the other. It does not become fixed. This fixation is very much aided by the exercise of the faculty of attention. If the sensation or action has to be in the future revived in the memory by an act of will, i.e., voluntarily, it is almost essential that there be attention paid to the first impression.

The faculty of attention is one still very imperfectly understood, but you all know how, in our wakeful state there is constantly passing through our mind a wave, on the crest of which is either the abstract thought, the perception, the conception, &c., which is engaging our immediate attention, whilst on the receding part of the wave are the thoughts, the perceptions, and conceptions receding gradually out of our attention, and in the front of the wave, the thoughts, perceptions, and conceptions which are gradually coming into our attention. What is on the crest one second is receding the next, but we are still conscious of its presence, although it gradually gets more dim and obscure. If this were not so, our wakeful state would have no continuity. It would be made up of isolated states of consciousness. Attention, therefore, in order to secure fixation in the memory, is almost essential for voluntary recollection, as those engaged in the education of children know so well. Whether it is possible for a person to have a memory fixed without attention at all is doubtful. Several cases have been recorded where very little attention could have been paid to the original impression.

After quoting an experience of M. Maury, cited by Taine (a), the lecturer continued: But it may be stated that generally when no attention is paid to an impression, the memory of it does not become fixed. All of you know that you may pass along a road or a street and not be able afterwards to recall a single person or thing you passed, although your eyes must have rested on many persons and things. On the other hand, impressions may become firmly fixed in the memory, and usually, if not always, this firm fixation in the memory results from the attention having been intensely fixed on the cause of the impression.

A beautiful view, an interesting book, a good story, a striking illustration, get all fixed in the memory readily, and this fact is taken advantage of every day in the education of children and others.

Of what does this process of fixation in the memory consist? We do not as yet understand this fully, but it may be stated that when a sensory impulse is conveyed from an organ of special sense to a cell in the sensory centre, an effect is produced which is to some extent a permanent effect. I do not discuss here the question, which is a debatable one, whether the effect is produced in the cell itself, its branches (the so-called dendrites), or in the apparently more structureless material in which the cell is embedded. The changes produced by nerve action in nerve structures are still beyond our methods of investigation. Changes certainly do take place in the nerve cells after prolonged action. Thus,

much has been shown by the microscope, and the chemist also has detected chemical changes, but little more can be said. Probably the change that takes place is purely a molecular one, and may be compared to the change which takes place in a basin of water after being stirred. The water is apparently the same, but the molecules must occupy a different relative position to each other.

A more important thing, however, than mere change in the nerve element is the fact that the cell or nerve element which has received the nerve impulse retains the memory of the impulse. In other words, there is a *retentum*—a something retained in the nerve cell or element which makes it easier on a future occasion for the same impulse to produce the same effect; and not only so, but this *retentum* makes it possible for the individual to revive the previous sensation from above, this is, by ideation, and to recognise the sensation when it has been roused.

Taking the cell as the element, therefore it is essential for complete memory or recollection of a sensation that it be:—

1st. Fixed in the memory by a sufficiently intense and durable primary sensation accompanied by attention.

2nd. That it be reproduced either by an act of will, or by a similar sensation or association of the previous sensation.

3rd. That the reproduction or revival be recognised as similar to the original sensation.

Now, these essentials of a complete memory are proved to be separate processes and dependent on different physical bases by the fact that any of them, or all of them may be disorganised by disease.

After giving examples the lecturer continued:—Let us now inquire in what this revival consists, what takes place in the nerve cells, or other nerve elements, when a person revives anything in the memory. When such a revival takes place by a repetition of the same sensory impulse, probably we have a repetition of the same process in the nerve elements. Does the same thing occur when one revives a memory in ideation only; when, for instance, one thinks of any object, a chair, a picture, &c., which he may have seen at a previous time? There can be little doubt that there is a repetition of the same nerve processes in the same nerve elements as took place when the object was originally before the eyes.

This has been well expressed by Bain, (a) who says that it is quite demonstrated that the impression renewed occupies exactly the same parts, and in the same manner as in the primitive impression. As an example experiment shows that the persistent idea of a brilliant colour fatigues the optic nerve. If one thinks intensely on a coloured object with the eyes closed, and then open the eyes and look at a white surface the coloured object is seen in the complementary colour. This fact, Wundt says, proves that the nervous operation is the same in the two cases, viz., in the primary perception and in the revival of the same in the memory.

You will see at once how this has a bearing on the question of the seeing of objects and persons that are not present, and the hearing of voices when there is no one near to produce the voice. In fact, how it is possible to explain in this way many of the experiences and experiments of Spiritualists.

In *visuale*, for instance, it is possible for a visual memory to be so intensely and completely raised by the same nerve processes in the same nerve elements as received the original impression of, for instance, a person long since dead, that the idea of the person may be so complete as to appear to the individual actually existing before his eyes. This is the explanation of illusions and hallucinations, which occur in fevers and in diseased states of the brain, but that such phenomena occur also in apparently healthy persons, there is little doubt. This, however, is somewhat apart from our subject, although it opens up some very interesting questions.

From what I have already said, it will be concluded, therefore, as stated by Ribot, (b) that there is not one

(a) Bain—The sense of intelligence quoted by Ribot, "*Maladies de la Mémoire*."

(b) Ribot—" *Maladies de la Mémoire*."

(a) Taine on Intelligence.

memory, but there are memories; that there is not one seat of memory, but there are special seats for special memories.

We have, therefore, seats of memory corresponding to the sensory centres of the special sense organs. Visual centres containing visual memories, auditory centres containing the auditory memories, gustatory centres containing the gustatory memories, and so on, and on the production side we have motor centres containing the motor memories, and in the higher psychical centres we have located the memories of abstract thought and higher psychical memories.

All these memories may be associated in innumerable ways, as I have previously pointed out, by commissural nerve fibres, and hence the importance of association both in the fixing and the reviving of the memory. Most systems of memory cultivation take advantage of this power the brain possesses of associating one nerve impulse or action with another. If an impulse is properly associated in the primary reception, it is much more easily revived. And how much more easy it is for one person to revive memories than for another. Why do we differ so much in our power of recalling to memory?

From what I have just said, it will be seen why one person can remember almost everything he has seen, whilst another remembers what he has heard. Why one person never forgets a face, whilst he cannot remember names; another can't remember faces but never forgets names. Why one has asplendid memory for figures, whilst another is no arithmetician. Why one person has a good knowledge of music, whilst he cannot produce music. Why, in fact, each of us is probably better at one thing than at others. The explanation of these differences is to be found in the fact that there is not one memory, but particular memories located in different areas in the brain, and also in the fact that we vary immensely, not only in the quantity of our nerve elements in these centres, but also, even more so, in the quality of these elements. We vary also in our experiences, and in our methods and manner of education, so that the differences I refer to, if not originally present, gradually show themselves.

What bearing has all this on the education of children?

As I have said sensory memory goes before, and, indeed, must to some extent go before memory. We, for instance, hear and understand language before we produce language for ourselves. We see and understand written and printed language before we learn to write it. This is the natural order in which we learn language, and this may be taken as the type of all our cerebral processes. It is the scientific basis of the old advice, "to look and think before you speak"—in other words, first, observe; secondly, reflect; thirdly, act.

Without the thorough training first in the concrete by laying in a stock of sensory memories, and allowing these to be drawn upon by the higher psychical centres, every action which ought to be based on these memories becomes mechanical, is expressionless, fails in its object, produces the minimum good result to others, and last, but not least, gives little or no pleasure to the child producing it.

After illustrating these points in the teaching of the various arts the lecturer concluded, of course children differ in their faculties. All are not born musicians, born painters, born sculptors, born thinkers. Some have greater capacity for developing one faculty than others, but what I wish to point out is that it is useless to train a person to do anything without first training the sensory organs and centres, so that he thoroughly understands and mentally appreciates what he is to do. I do not wish to decry the training of the muscles to perform exact movements, but what I wish to emphasise is that these movements are so much finer and of a much more useful and divine character when performed in response to sensory impressions, the memory of past impressions and the higher psychical memories associated with the very soul of the individual. It is the difference between the instinctive and automatic, although exact actions of a lower animal, and the actions performed by a human being guided by feelings, by reason, by the dictates of morality, yes, by divinity itself. Let us, therefore,

study the minute capacities of children, their peculiarities as regard their dispositions and special talents. Let us train them in the concrete to observe, to make use of their senses, to lay in a stock of sensory memories. Let this stock be drawn upon for work, for amusement, for enjoyment, for abstract thought, and there is no fear but that actions will flow naturally and in a healthy and moral manner, and the result will ultimately be a good all-round morally and mentally healthy individual, who will not only be able to say at the end of his life that he has lived usefully, but that he has also lived happily.

AN HYSTEROSCOPE

FOR

GYNÆCOLOGICAL DIAGNOSIS.

By ALEXANDER DUKE, F.R.C.P.,

Cheltenham.



THE accompanying illustration represents an instrument which will be found useful to the gynæcologist in the examination of the os and cervix uteri. The diagnosis of the various forms of erosion will be facilitated, and the subsequent effects of the various applications better seen.

The recognition of the following will be materially assisted, viz.:—"Syphilitic erosion of the cervix," cervical papillitis, folliculitis, traumatic erosion (sometimes produced by ill-fitting pessary), and malignant disease of cervix in its early stages.

I have found the instrument a great assistance in observing the effects on the surface after the appropriate dressings had been applied, and it has helped me in the choice of the next application, a stronger or a weaker as the case required. The lens is so arranged on hinge, it can be placed at any angle by observer, and so direct the light more on the parts examined, and when used with artificial light acts as both a condenser and magnifier. The glass should be warmed before using, more especially in cold weather. It can be applied through any form of medium sized vaginal speculum (the lens measuring only one inch across), or with Sim's duckbill, in which case the handle to lens is most useful in keeping anterior vaginal wall out of line of vision.

The makers are Messrs. Mayer and Meltzer, Great Portland Street, London, W.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, MAY 11TH, 1900.

DR. SEDGWICK SAUNDERS, Vice-President, in the Chair.

DR. PRICKETT and Dr. F. E. BATTEN read an account of a case of

ACUTE ENCEPHALITIS FOLLOWING INFLUENZA, in a boy, æt. 9, who in January, 1899, suffered from a slight attack of influenza necessitating his being kept in bed for a day. He rapidly recovered, and although rather languid played with the other children as usual. On the morning of the fourth day after the attack, when

the French maid went to wake him for his bath, he spoke to her in French saying he did not want his bath and that his right arm felt funny. It was then found that his right arm was helpless. He was seen shortly after this by Dr. Prickett, who found that the boy was hemiplegic on the right side. He was aphasic but conscious, and understood all that was said to him. He now became progressively more and more drowsy and passed into a condition of coma and died 72 hours after the onset of the paralysis. The autopsy was performed nine hours after death. The dura mater and the sinuses appeared normal. The surface of the brain was pale and there was marked flattening of the convolutions, especially on the left side. The vessels at the base of the brain appeared normal, no thrombosis of the larger vessels being visible. On making a horizontal section through the hemispheres it was seen that the subcortical vessels, especially on the left side, were very much injected and stood out in contrast to the surrounding tissue. The condition was not limited to the left hemisphere, but affected the right also. The basal ganglia and the internal capsule appeared normal. On microscopical examination it was found that there were numerous small extravasations of blood and thrombosis of the finer vessels in the subcortical regions. The examination of the cells of the cortex showed that although the cells were somewhat swollen and their staining was diffuse, yet the nucleus and nucleolus were normal in situation and appearance. The medulla, pons and cerebellum were normal. The larger vessels at the base of the brain also appeared normal. The case was thought to be one of thrombosis of the smaller vessels of the cortex due to some toxin of which that of influenza seemed the most probable. Reference was made to the cases published by Strumpell, which although occurring in adults correspond both in their clinical picture and pathological condition with the present case.

THREE CASES OF CHOLEDOCHOTOMY.

Mr. W. H. BATTLE read a paper on three cases on whom he had performed the operation of choledochotomy. After commenting on the rarity of the operation as compared with cholecystotomy, and its greater danger, especially where the patient suffers from jaundice, or there are adhesions to the bile ducts, the notes on the following cases were read:—Case 1. That of a fat girl, *et.* 14, who was under the care of Dr. Hawkins in 1898, and who had had attacks of pain in the abdomen not well localised, sometimes severe, for a period of six months. Nausea and headache accompanied these attacks, and for these morphia was administered. The pain was referred to the umbilicus, and also to the left lumbar region. There was albumen and blood in the urine. No casts. X-ray examination was negative. Exploration of the kidney through lumbar incision showed the absence of stone. During convalescence from this operation she had no more attacks, but after her return home she had a severe attack, and on readmission, abdominal exploration showed the presence of a gall-stone in the cystic duct. The removal of this relieved all her pain, and when she left hospital some weeks later, the albuminuria had almost if not quite disappeared. She has continued well. Case 2. A single woman, *et.* 60 (under the care of Dr. Sharkey, 1898). From attacks of hepatic colic during four months. In this case the gall-bladder could be felt forming an elongated tumour rounded below and very hard to the touch, in fact it felt as if it had contracted down on some large stones. The wall of the gall-bladder was very thick, it contained no stones, but one was found in the common duct near the duodenum, and extracted through an incision in the wall of the duct. The result was very satisfactory. Case 3. A woman, *et.* 49 (under the care of Dr. Sharkey, 1899), with a history of 18 years' suffering. Attacks of paroxysmal pain with vomiting and general prostration. Had passed gall-stones and had suffered from jaundice. The gall-bladder could be felt. At the operation stones were found in the gall-bladder, the dilated cystic duct, and in the common duct (probably the diverticulum Valeri). Those in the ducts were removed through incisions in the duct walls, the opening, being sutured afterwards, as in the other cases, with single row of Lambert's

sutures of fine silk. The case did well. In each case the gall-bladder was opened and emptied of its contents, being afterwards sutured in the wound and drained. The stone was held up and steadied whilst the duct was incised over it, and escaping bile (quantity already lessened to a great extent by the incision of the gall-bladder) prevented from diffusion by gauze packing. In no case was there any trouble from adhesions, and none of the patients suffered from jaundice. In a recent case of obstructive jaundice which he was exploring he had found a distended gall-bladder which diminished in size during manipulation. A stone lying loose in it was removed, and ultimately the jaundice disappeared making it probable that the stone had escaped into the duodenum during the operation.

A GALLSTONE IMPACTED IN THE DUODENAL ORIFICE OF THE COMMON BILE DUCT EXTRACTED THROUGH AN INCISION IN THE BOWEL.—RECOVERY.

Mr. BLAND-SUTTON related the details of a case in which a woman was operated upon for "Gall-stones." In the course of the operation a calculus was detected in the wall of the duodenum impacted in the terminal segment of the common bile duct. As this concretion could not be pushed onwards into the bowel nor upwards into the gall-bladder, the wall of the duodenum was incised, and the bile papilla exposed: the calculus could be seen slightly projecting through the orifice, and after nicking the edges of the papilla, a gall-stone as big as a Barcelona nut was extracted. The incision in the duodenum was sutured in two layers, and the wound in the abdomen closed in the usual manner. A narrow strip of sterilised gauze was inserted as low as the duodenum. The convalescence was retarded by an attack of suppurative parotitis on the right side due to a staphylococcus. The wound in the abdomen healed without any irritation. The nucleus of the gall-stone consisted of a collection of the bacillus coli communis. Six months later, the patient was reported to be in excellent health.

Dr. PARKES WEBER remarked that at the German Hospital the house surgeon was examining a man with jaundice, probably catarrhal, who had a large gall-bladder which disappeared under his fingers while he was palpating it, and the stools, which were clayey before, forthwith became coloured. That, apparently, was not a case of obstruction from gall-stones. In another case which he had an opportunity of examining, the gall-bladder suddenly diminished in size, but a hard lump remained which proved to be a calculus.

Mr. CHARTERS SYMONDS asked Mr. Sutton what means he took to keep the common duct in place when removing a stone or suturing it, that being the principal difficulty in these cases. He referred to Halsted's ingenious little hammer with this object in view. He could recall five cases in which he had removed stone from the duct in various positions. He passed a silk suture above and below the stone, and these, after removal of the stone, served as a guide for the introduction of the closing sutures. In one case he had used an interrupted suture and a fistula remained for some time. He discussed the best route to approach the duct, observing that the ordinary incision along the outer border of the right rectus had sometimes been found insufficient, in fact it was sometimes easier through a median incision. He had even had to cut across the rectus muscle altogether. He remarked incidentally that it was more difficult to reach the duct in man than in woman. He related the case of a woman very deeply jaundiced, in which, on operating, he found a hard mass over the head of the pancreas. In spite of the probability of this being malignant, he continued the operation, and discovered two gall-stones in the duct, close to the pancreas, which he removed. That patient afterwards developed cancer in the lung and liver. He thought that in removing stones from the common duct most of them drained the gall-bladder. He urged leaving a tampon *in situ*. In some recent cases he had drained the gall-bladder, and he suggested that where the duct was very capacious they might close the wound and get primary union, but where the gall-bladder was much enlarged, he thought it was unwise not to drain. He discussed the necessity for suturing the duct, observing,

that if this could be dispensed with it would greatly facilitate the operation. He recalled Halsted's suggestion that the distress caused to the patient on withdrawing the tampon might be obviated by covering it to a great extent with gutta serena tissue which prevented its adhering to the skin.

Mr. BLAND SUTTON, in reply, mentioned that in a case reported in Vol. 25 of the *Transactions* he had drawn attention to the fact that he had simply drained the wound without suturing the duct, a procedure which Mr. Hulke at the time described as "risky." Since that time he had done quite a number of these cases without troubling to suture the duct, which, indeed, it was often difficult and impossible to do. At present he never felt the least temptation to put a suture in.

Dr. F. PARKES WEBER on a case of

PNEUMOTHORAX WITHOUT EFFUSION IN AN APPARENTLY HEALTHY MAN.

The patient was a piano-fitter, *et.* 31, without previous history of pleurisy, hæmoptysis, or pulmonary disease, and without any family history of consumption. Without any violent strain or excitement, whilst doing his work, he suddenly felt a pain, like a knife sticking into him, on the left side of the chest. His breath gradually became shorter, and the pain was very much increased by attempts to walk. On arriving at the hospital shortly afterwards his respirations were about 30, and his pulse about 65. The movements were equal on the two sides of the chest, but no cardiac impulse could be felt; the cardiac dulness was displaced to the right of the sternum, and there were distinct signs of pneumothorax of the left side. When the patient was kept quiet in bed the dyspnoea and severe pain in the chest rapidly left him. No splash-sound or proper metallic tinkling were ever heard, and the signs of pneumothorax gradually disappeared in the course of 32 days. The first evidence of partial return to the natural condition was afforded by the absence of the bell sound from the upper front part of the affected side of the chest; the most persistent of the abnormal signs was the displacement of the heart. During recovery from the pneumothorax, the patient did not appear in any way ill. There was never any expectoration, or any sign of pleurisy or pleuritic effusion of serum, blood or pus. The present case and similar cases, including the rare cases of recurring pneumothorax, can be best explained on the supposition that a subserous emphysematous bulla has burst, or that a minute tuberculous nodule has broken down and opened up a communication between the air passages and the pleural cavity. Emphysema is commoner in males than in females, and practically all the cases of pneumothorax in apparently healthy persons have occurred in males. On the other hand, some cases, such as one described by Dr. S. West, seem to have been due to slight tuberculous changes in the lung, insufficient in degree to seriously affect the general health.

Dr. PERCY KIDD related a very similar case in a young man, who, without any previous history, suddenly developed pneumothorax without known cause. This cleared up completely in the course of a fortnight, in spite of the most reckless disregard of his instructions. He remarked on the remarkable tendency of this condition to undergo spontaneous cure.

LARYNGOLOGICAL SOCIETY OF LONDON.

At the April meeting of this society (Dr. de Havilland Hall, president, in the chair), Sir Felix Semon showed a case of laryngeal (?) whistling in a boy, *et.* 13. The whistling noise could be made with the laryngoscopic mirror in position, and was apparently produced by the vocal cords.

Dr. DUNDAS GRANT showed (1) a case of rhinoscleroma in a female native of Russia improving under treatment with lactic acid; (2) a case of growth in the nasopharynx, probably cystic; (3) a specimen of a larynx completely removed on account of sarcoma; and (4) a case of primary syphilis of the fauces.

Dr. St. CLAIR THOMSON showed a girl with chronic

laryngitis from inherited syphilis showing recesses in cavern formed by Luschka's tonsil.

Dr. TILLEY showed (1) six cases of frontal sinus suppuration, in five of which he had performed the external operation; (2) a microscopic specimen of angioma removed from the nasal septum; and (3) a case of adenoids associated with an abnormal pulsating vessel in the pharynx.

Mr. CHARTERS SYMONDS showed a case of oesophageal stricture which had apparently been present for two years and had been treated by tubage for one year. The man was still in good general health.

Mr. SPENCER showed a girl with extensive necrosis following suppuration in the frontal and other nasal accessory sinuses.

Mr. YEARSLEY showed a case of malignant disease of pharynx and larynx; and Mr. ROUGHTON a child, in whom there was considerable difficulty in removing a tracheotomy tube which had been worn five months.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, May 12th, 1900.

PROLAPSUS OF RECTUM.

At the last meeting of the Académie de Médecine, M. Delorme related the cases of three patients who suffered from prolapsus of the rectum, and who were treated by excision of the mucous membrane and by circular sutures. One of the patients died, the two remaining were cured without relapse. According to the speaker, ablation of the mucous membrane usually reserved for prolapsus of the mucous membrane only, was likewise applicable to prolapsus of all the coats of the rectum.

The operation was especially indicated in the adult and in the child, whose tissues presented particularly favourable conditions of adhesion. The excision of the mucous membrane should not be too extensive, six to ten inches were sufficient. Consecutive treatment had a considerable importance as to the result of the operation. It consisted in fixing the anal region until the cicatrix was complete. To obtain that result it was necessary to apply an occlusive dressing which would insure the perfect contentment of the parts. The legs should also be attached below the knees, so as to prevent any movement. The patient should remain several days without defecation, and to meet that necessity small doses of opium should be prescribed as well as a rigid diet. To consolidate the cure walking should not be allowed before several weeks.

TREATMENT OF MYOPIA.

M. Panas read a paper on the treatment of myopia without operation. It was a case of a boy in whom myopia was very pronounced. He was treated by instillations of a solution of pilocarpine, several times a day, and the application of a compress of wadding at night. At the end of five months the improvement was very encouraging, the anterior posterior axis of the ocular globe was manifestly shortened by the compression and the instillations of pilocarpine.

ANEURISM.

M. Tillaux related at the Surgical Society how he placed a ligature on the aorta by mistake in operating for an aneurism of the external iliac artery. A man of 56 entered the hospital with a tumour in the left iliac fossa. For a year previously he remarked a small tumour in the region, for which he was advised to wear a bandage. A few days before entering the hospital

he strained himself, and almost immediately the tumour became the size of an adult head. The case was one of diffused aneurism. The speaker decided on tying the iliac trunk, and after having placed the ligature as high up as possible, he was able to state that no pulsation took place in the tumour. The following day the condition of the patient was as satisfactory as possible, but a fortnight afterwards oedema set in in the leg, and the man succumbed forty days after the operation. At the autopsy the operator discovered, to his great astonishment, that he had inadvertently tied the aorta.

EPITHELIOMA OF THE FACE.

A member presented a patient whom he had treated successfully for extensive epithelioma of the face and head by the method of Cerny-Truneek, or by painting the surface every two days with a solution of arsenious acid, 1—1.00. Under its influence large plates of the diseased bone were detached, and the process of reparation followed normally.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, May 12th, 1900.

At the Surgical Congress, Hr. Rehn, Frankfort, gave an address on

IMPROVEMENTS IN THE TECHNIQUE OF RESECTION AND AMPUTATION OF THE RECTUM,

Our aim, he said, was to make advances, either in early diagnosis or in improvements in technique. The first was difficult, often impossible, as a number of cases of cancer of the rectum ran on a long time without presenting symptoms. Kraske had done good service in introducing the sacral method, but it had been carried too far and the backward swing soon followed. The method demanded its victim, the sphincter was sacrificed, and various modifications were attempted. The improvements were in the direction of retaining the coccyx, and osteoplastic resection were performed. The influence of the new procedure on the final result was unimportant, and in many cases disadvantages followed.

On the whole we have made distinct advances, but they were of no great importance. The sacral method was a dangerous operation that indeed afforded a free field of operation. But it necessitated a serious wound, that was difficult to treat afterwards, and the retention of the sphincter was often useless. Recently the attempt had been made to attack the carcinoma from below, and the vaginal operation had been introduced.

The speaker then passed on to the anatomical relation as given by Waldeyer. He described and demonstrated by diagrams the ramification of the lymph vessels, and the anatomical relation of the sphincter region. The various sphincters formed a muscular closing apparatus working in common, which was surrounded by fascia. The upper border corresponded to the attachment of the peritoneum. By lateral attachment to the hypogastric vessels a pre-rectal and a retro-rectal space were formed. The lymph vessels were always placed laterally. The conclusions of the paper were as follows:—Extirpation of the diseased rectum from the sacrum was not to be recommended. A method was to be preferred that afforded free opening and high extirpation, with sparing of the fascia, easy arrest of hæmorrhage, good muscular closure, and the utmost possible avoidance of infection

Carcinomata, therefore, that had grown beyond the fascia should not be operated on. The best method in the male was the perineal. The incision was essentially that of Dieffenbach's operation. When no attachments were present the space should be opened up anteriorly. This part should then be tamponaded and the posterior space opened up. As much as possible of the intestine above the carcinoma should be removed; after extirpation the central end should be drawn down and made fast. The after treatment was much simpler than after the sacral method, and exit for secretions from the wound was easy. In one case he had removed 21 cm. of bowels by this method, and the result was very favourable.

The operation was somewhat easier in women. Here simple incision of the vagina gave a good view of the field of operation. He had operated in 18 cases with only one death, and in this the outflow of secretion was good. Movable tumours were readily removed, but if the glands were affected they must be reached from the abdomen. Regarding this combined operation, however, we had not much experience.

This method best assured the maintenance of normal conditions. He had seen gangrene of intestine as the result of insufficient nutrition from too much dragging down of the bowel.

Hr. Hochenegg reported on

120 OPERATIONS ON THE RECTUM FOR CANCER

performed by himself.

He differed from the other surgeons in believing that the sacral method was better than the other, and that it was neither more difficult nor more dangerous. He therefore looked upon it as the normal operation. Only when the carcinoma was situated in the lowest part of the rectum was the perineal operation suitable. In thirteen years he had performed the operation 121 times with only ten deaths. The advantages of the method consisted in exact performance of the resection, in good arrest of hæmorrhage, and favourable condition for drainage afterwards. He had not selected his cases, and the only contra-indication was excessive infiltration in the pelvis. He could look back upon thirteen permanent successes. In case of ileus, colostomy was first performed, and the sacral operation three weeks later. He had stuck to the old method of operating, but the coccyx was always removed. This, however, was freed extra-fascially, and made as movable as possible for freeing it from intestine. It was essential to retain the anal portion if sound, if otherwise it was removed. In the first case the intestine was drawn through the anal portion in order to prevent the escape of faeces in the abdominal cavity. The bowel must, however, be fixed without any tension. The greater part of the posterior wound remains open, for the purpose of facilitating drainage. On the fourth day, if necessary, castor oil was given.

As regarded results circular sutures gave excellent results, but not always. In four cases there was relative incontinence, i.e., inability to retain liquid motions. In some cases the suture did not hold and a fistula formed this had to be closed later by a plastic operation.

In case of recurrence he never did a second operation, no good results followed. Of the fatal cases since 1887 4 had died from sepsis, 2 from hæmorrhage, 4 from accidental causes (influenza, cerebral embolism, &c.). Sub-

tracting these 4 cases the mortality was 6 cases, or 5 per cent.

Hr. Körte followed with

EXPERIENCES IN OPERATIVE TREATMENT OF MALIGNANT TUMOURS OF THE COLON.

Completed operations 51. There were 6 tumours of the ileo-cæcal region, all recovered, no recurrence in 3 years in 3 cases.

Six tumours of the hepatic flexure and transverse colon, 2 recovered, 4 died. No recurrence in 5 years in 1 case.

Seven tumours of the descending colon and sigmoid flexure, 4 recovered and 3 died.

Palliative operations: 12 enteroanastomoses, 3 deaths; 20 enterostomies, 6 deaths; 2 ileostomies; 8 cæcostomies; 9 iliac colostomies (left); 1 transverse colostomy.

The speaker showed five cases with permanent recovery after intestinal resection for malignant tumour. Two of carcinoma of the ileo-cæcal region, 8½ and 6 years respectively; 1 (tumour of the valvula Bonchiri), 5 years; 1 (tumour of transverse colon), 6 years; 1 (carcinoma of descending colon), 3 years.

Ileus had a very unfavourable influence on the results of an operation. Of 29 cases in which operation was performed, ten died. As regarded delay in cases reaching the surgeon, out of 43 cases, operation was practicable in 19 only. The results obtained he does not consider brilliant, but they were an encouragement to proceed on a better line.

Hr. Kraske was a firm supporter of the sacral method. It did everything that could be desired of a method of operation, especially as regarded mortality, as Hochenegg's material showed. His own 120 cases did not show such good results, as these embraced the unfavourable results of the early days of the operation. This students fee had been spared to later operators.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, May 12th, 1900.

SYPHILITIC INFECTION AND TREATMENT.

At the last meeting of the "Medical Club," Lang read a paper on infection by, and the treatment of, syphilis. He was of opinion that the serum treatment should be prescribed to act as a prophylactic, even though the syphilitic bacteria be not found, but it should never be used as a diagnostic agent. As to the treatment, he thought the inhalation form the most effective and the safest; indeed, the truth of his argument, he said, was proved by the large number of cases of indirect mercurialism produced by the inunction treatment. In those cases of syphilis where the central nervous system is dangerously affected, calomel injections are the safest and most efficacious. Inunction and injections of "grey oil" are also recommended. He had found the injection of this oil most useful locally when in the neighbourhood of gumma.

PETROSULFOL.

This is a new external remedy introduced by G. Hell and Co., manufacturing druggists, of Vienna, which Dr. Ehrmann has been using in his wards during the

past year. In his report of the drug he extols its efficacy as superior to ichthyol, to which it is closely allied in composition, being the product of a bituminous stone, but differing from ichthyol in being largely impregnated with sulphur. He has found it most successful in eczema, particularly in the follicular, squamous pustular, dry, or slightly weeping forms. It is not so well adapted for the treatment of cases having a great amount of discharge, for which boracic ointment will be found preferable. He relates the history of 462 cases treated with petrosulfol, among which were 40 of sycosis. In his eczema list were 80 cases of squamous eczema on the forearm and hand; squamous eczema of hands alone, 90; around the neck, 42; squamous eczema *en plaque*, universally spread over the trunk, 37; and 56 eczema scroti, vel. labiorum. The others consisted of eczema of toes, feet, armpit, knees, anus, and the "keratoid eczema" of Unna on the legs, which is only another form of the thick squamous eczema on the lower extremity.

Ehrmann applies it either in the form of an ointment or paste:—

℞ Petrosulfol, 4·00 grammes;

Ung. casein, 20·000 to 40·00 grammes;

or a paste:—

℞ Petrosulfol, 6·00 grammes;

Lanolin;

Vaselin (flav. Americani), 22 20·00 grammes;

Oxide zinci, amyli (or talci Veneti), 22 10·00 grammes;

Fiat pastam.

If the paste be too stiff half the quantity of oxide of zinc and starch may be used. When applied it may be left uncovered or protected with a gauze bandage. The linen may be stained by contact, but this is easily removed. In general the application is successful in from two to five weeks. In six cases of eczema keratoides on the upper extremity, and one case of eczema on the lower where the disease had persisted for years, it entirely disappeared within three months after the first application. Two cases of the same class, however, were very little improved by its use.

The squamous and papulous form of eczema will disappear in two or three weeks under its use. Purulent follicular eczema of the scrotum also recovers quickly. Pustular sycosis coccogenes is another disease that is improved by it; both hypogenic and coccogenic are cured within 14 days, if assisted by the electro-kataphoretic treatment, the petrosulfol being applied by the kathodic pole. The kataphoresis is applied daily for a quarter of an hour at each sitting.

To test the theory of this treatment Ehrmann made a 10 per cent. gelatine culture medium of petrosulfol, and attempted to grow staphylococcus pyogalbus and aureus, but failed, though below this percentage growth could be observed. This led him to use a 10 per cent. plaster of petrosulfol to the skin of a patient, covered with coccogenic pustules; after its application the cocci disappeared from the pus and the skin rapidly healed. In furunculosis the same phenomena were observed. Stripes of petrosulfol are also efficacious in lymphangitis and erysipelas. In hyperidrosis the best results can be obtained with the petrosulfol zinc paste. In a hundred other cases of an allied nature Ehrmann has applied the drug in varying forms of powder suppository and wash with satisfactory results

Special Article.

MEDICAL POLITICS AT MANCHESTER.

IN the field of medical organisation there is room enough for man workers, and we congratulate the members of the Medical Guild, who inaugurated the Conference at Manchester on medical organisation, on having attracted so many delegates to their meeting. The mere fact that such a movement has been started successfully is, in itself, a sufficient justification of the need for the effort which has been initiated and carried through under the direction of Dr. S. Crawshaw, to whom, as Honorary Secretary, a large share of the work must have fallen. Delegates representing 4,000 medical men assembled at Manchester for this Conference, and although during the three days on which the Conference sat, too much was said about medical grievances and not enough about medical organisation, still, the net result must not be lost sight of, for the labours of these gentlemen have placed clearly before the profession the fact that medical men as a body are, to use Dr. Jepson's words, "an homogeneous mass, having similar elements, but each element or atom pursuing his own way, having no care for the wants of others." To remedy this deplorable condition the Conference decided to institute all over the country medical unions whose duty it will be to choose delegates to attend a conference on Medical Organisation, to be held every year. The sincerity and honesty of purpose displayed by the delegates was apparent to all, and in drawing attention to what may perhaps be the unavoidable concomitants of the first attempt at such a Conference we must not be misunderstood to be doing otherwise than making recommendations more for guidance on future occasions than for reproof in respect to this present meeting. It is an easy thing to say the Conference should only have discussed medical organisation, and that the importation of debates on medical grievances should have been sternly prevented, but it is the very rarity of such opportunities for the discussion of wrongs that irresistibly impelled the delegates to embark on such burning questions as the Midwives Bill, and the undoubted scandalous prevalence of hospital abuse. Instead of holding these gentlemen up to the ridicule of the profession, as we are sorry to see has been done by one of our more modern contemporaries, all right-minded men will recognise in the misuse of the time of the Conference a further emphatic proof of the increasing stress of the grievous burdens and heavy disabilities under which the ordinary practitioner has to earn his daily bread. To organise on a large scale means heavy expenditure, and the Manchester gathering was quite practical enough to grasp that important elementary truth. The solution of this particular problem was, however, satisfactorily dealt with by the practically unanimously agreed upon plan to "collar" in a constitutional manner the accumulated funds of the British Medical Association. How this desirable object from their point of view was to be attained was not very evident, but one thing was quite clear—they must turn up at the Annual General Meeting of the British Medical Association at Ipswich this summer, and insist on their rights as directors of a limited liability concern to elect on the Council of the Association the men they wanted. Whether this arrangement will succeed will be

seen in due course, but much preliminary rejoicing was evinced on Dr. Brassey Brierley informing the meeting that the Council of the Association had received legal opinion that the resolutions passed at annual general meetings must be recognised by the Council as definite instructions. This was recognised by all as a very important step forward in the slow process of making the British Medical Association a really representative body. It is in no captious spirit of carping criticism that we next draw attention to what may be euphemistically termed an "error in judgment" on the part of the Conference. We refer to the attack on the public vaccinators who were accused of using the powers entrusted to them by the Act for the purpose of attracting patients from their colleagues. It would serve no useful end to recapitulate in detail the serious charges made against a large and respected section of our medical *confreres*, but it is matter for satisfaction that the Conference refused (though by the bare majority of two) to crystallise these charges into an official resolution. To have allowed the discussion to take place was a blunder from the point of view of expediency, for it gave occasion for the administration of some justifiable rebuke. Dr. Major Greenwood indignantly declared that to put forward such imputations of meanness and dishonesty was unwarranted, and he was followed by Dr. Brassey Brierley, who asked in vain for direct and complete proof in support of such reckless charges. It was probably largely due to the temperate and well-balanced speech of Dr. Woodcock that the Conference was saved from the disastrous consequences of passing the unwise resolution proposed. It is a curious indication of the absorbing interest taken by the ordinary practitioner in the midwives' question, that try as the Chairman might it was found impossible to prevent the midwife and her shortcomings being dragged in or attempted to be introduced into every debate of the Conference. To such an extreme did it arrive that the question of exterminating these women was actually under discussion, Dr. Cox, of Gateshead, however, in the end explaining that by extermination was meant the education of public opinion to discontinue calling in midwives. This evasion was recognised as ingenious, but the transparent avoidance of avowing what was really meant by the term "extermination" deceived no one. As the polite curate said of his questionable egg at his bishop's breakfast table, the Conference on medical organisation at Manchester was "good in parts."

The Operating Theatres.

GUY'S HOSPITAL.

GASTRO-ENTEROSTOMY.—MR. ARBUTHNOT LANE operated on a man, æt. 45, who was suffering from dilatation, apparently due to a growth about the pylorus. On exposing the stomach, as was expected the growth was found to be of a very extensive nature, extending from the pylorus to a considerable distance over the wall of the stomach, and there were a large number of enlarged glands above it in the lesser omentum. Under these circumstances any attempt to effect complete removal of the disease was out of the question, so he connected a portion of the anterior surface of the convexity of the stomach at a distance from the margin of the

disease to the commencement of the jejunum by means of a Murphy's button. He called attention to the fact that though he was the first in Europe to employ Murphy's buttons, and though he had used them continuously since, he knew of no case in which their use had produced any harm whatever to the patient. He believed that the reason Murphy's button had proved unsuccessful in some hands was due chiefly to the use of too large a button; secondly, to imperfect purse-stringing of the orifice; and thirdly, to damage sustained by the bowel from the pressure of the fingers in forcing the two segments of the button home; fourthly, to the use of buttons which had been improperly constructed, or, if these had been properly constructed in the first instance, they had been allowed to get into an unsatisfactory condition, especially if they had been previously used. Unfortunately, he said, while all institutions, almost without exception, regarded extravagant expenditure for building purposes as perfectly natural, they were all inclined to grudge money for the instruments upon which the safety of the patients depends directly, and he thought economy in this direction should be most strongly deprecated. He believed that many lives are lost in this manner. He felt we owed a great debt of gratitude to Dr. Murphy for his button.

OPERATION FOR CHRONIC APPENDICULAR ABSCESS.—

The same surgeon operated on a man, *æt.* 26, for chronic suppuration about the appendix in which there were one or more apertures of communication with the bowel. Before the patient came under Mr. Lane's care several attempts had been made to close the wound by the free opening up of abscesses and sinuses but without any result. As time was a matter of vital importance to the patient Mr. Lane determined to interfere at all risks; consequently he opened up the suppurating areas in the planes of the abdominal muscles, and cleaned the parts as he went on as thoroughly as circumstances permitted; he then found an abscess about the cæcum and two apertures of communication with this portion of the bowel at a distance from one another; the upper one he was able to close by cutting away the margin of the orifice, turning its edges in, and securing them firmly, while the lower offered more obstacles to this form of treatment because of the inflammation in the vicinity; this opening, however, he was finally able to close. Then he removed the appendix, which presented a large perforation within half-an-inch of its distal extremity. A gauze plug was left in the abdomen surrounding the cæcum, to be removed at the end of one or two days. Mr. Lane said that these cases in which communication with the bowel exists, and especially when they are associated with fairly extensive suppuration in the vicinity, often cause the surgeon much trouble and anxiety. He thought that risks both during and after the operation could be very much diminished by reducing intra-abdominal tension as much as possible before operating, and so preventing the bulging of coils of intestine into the wound, and also by the use of a gauze plug moistened with some irritating germicide, such as carbolic lotion, which, on its removal, brought about almost an immediate adhesion of the peritoneal surfaces inflamed by it, and so shut off the general peritoneal cavity. Another factor of vital importance in operations of this sort was, he thought, the degree of skill and intelligence of the assistant, since

any lack of them may result in extensive and possibly fatal fouling of the peritoneum.

DILATATION OF THE STOMACH FROM ADHESIONS ABOUT THE PYLORUS.—

The same surgeon operated on a woman, *æt.* about 67, who had for 10 or 15 years suffered acutely from pain in the epigastric region; this was particularly severe at night time commencing at about two o'clock in the morning or earlier, and completely depriving her of health, comfort and happiness. The dilatation of the stomach was only moderate, and at no time had she suffered from sickness or any of the more usual symptoms of dilatation. On placing her in the erect posture a definite suspicion of resistance could be felt extending downwards and inwards from the position of the gall-bladder, which itself, however, felt normal to the finger. There was no history whatever of biliary colic, or evidence of inflammation of the gall-bladder. An incision was made in the abdominal wall over this area, when the pylorus was found to be firmly attached by adhesions to the under surface of the neck of the gall-bladder, while to the area of the gall-bladder immediately in front of the pylorus the hepatic flexure was similarly attached, obstructing in a marked manner the exits of the gastric contents: the wall of the stomach was very thick and, as expected, the stomach itself was not excessively dilated, though the dilatation was very marked. This absence of extreme dilatation was probably explained by the obstruction being only partial and was to a large extent compensated for by a considerable hypertrophy of the inside wall. Both the transverse colon and the pylorus were thoroughly cleared of their connections with the gall-bladder and the parts in the vicinity by a careful division of the peritoneal adhesions, and the result was so satisfactory that no other means of draining the stomach into the bowel was necessary.

It is satisfactory to state that the subsequent progress made by all these cases was uniformly good.

THE Monmouthshire County Council has decided to allocate the sum of £1,000 to the Brentry Victoria Homes, at Bristol, which will entitle the Council to seven beds for their chronic inebriates.

THE exhibition of hygiene at Naples was formally opened on Wednesday last in the presence of the King of Italy, the Prince of Naples, the Duke of Genoa, Dr. Baccelli, Minister of Public Instruction, &c.

THE New Hospital for Women, Euston Road, London, has been added to the list of recognised institutions from which the University of London receives certificates for the purpose of its examinations for the degree of Doctor of Medicine.

THE Annual Conversazione of the Medical Society of London will be given in the Society's rooms, Chandos Street, W., on Monday, May 21. There will be a reception by the President at 8.30, and an Oration will be delivered by Dr. Kingston Fowler at 8.45, on "Science and Medicine in the Eighteenth Century."

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, MAY 16, 1900.

MR. TREVES ON MILITARY SURGERY.

THE interest taken in the surgical aspects of the present war in South Africa may be gauged by the affluence of fellows at last week's meeting of the Royal Medical and Chirurgical Society, which was probably a record evening in this respect. There is a general feeling that the experience gained in the present campaign will, when properly studied and digested, go far to revolutionise principles as well as practice, not only in the art of war, but in the province which is peculiarly our own, that of military surgery. Although the moment is not yet ripe for deducing any far-reaching conclusions from the experience at present available Mr. Treves was enabled to show that conditions have changed immensely in regard to the treatment of the wounded in war. They have changed for the better in respect of the organisation of skilled assistance and treatment. The mobility and resources of the modern field hospital place the treatment of the wounded on quite another footing to that which obtained at the Crimea, for instance. Moreover, surgery itself has made giant strides since then, and hospital gangrene, once the destroying angel of camp hospitals, if not quite banished, is no longer the fearful visitor which it once was, thanks to the introduction of antiseptics. A study of modern firearms and projectiles appears to be an indispensable preliminary to that of the treatment of wounds, the treatment whereof must necessarily depend largely upon the nature of the missile, its velocity, its size and shape, and finally of its physical characters. The special features of the wounds inflicted by modern rifles are, in the main, due to the conformation of the bullet and to its rotation on its long axis. It is small, possessed of wonderful penetrating

power, and does not, as a rule, exhibit that tendency to become deformed and split up which, in missiles of older date, was the cause of such widespread damage to tissues and structures. The large proportion of recoveries after apparently very severe injuries of the abdomen and head positively amounts to a revelation; but while surgical intervention is regarded by Mr. Treves as necessary in practically all cases of wound of the brain, it is quite the reverse when the bullet has traversed the abdomen, indeed the most striking of the lessons taught by recent experience is that, except in a narrowly circumscribed group of cases, operations for the relief of abdominal injuries are formally contra-indicated, some 60 per cent. of the injured recovering if left alone. A not less important lesson is that the chance of recovery is influenced far more by the sufferer being placed under favourable conditions in respect of non-removal than by any surgical treatment whatsoever. Not the least interesting and instructive portion of Mr. Treves' address was that in which he discussed the views enunciated in existing text-books on military surgery in the light of his recently acquired knowledge. Almost all urgently require revision, and our teaching in regard thereto will forthwith undergo profound modifications. One of the most valuable results of the despatch of eminent surgeons to the front will certainly be the opportunity thus afforded them of turning to account the information thus obtained in a way that we could scarcely hope for from army surgeons, however skilful, the conditions of service precluding the latter from criticising as freely as might be desired the administration of which they form part.

A FLAW IN THE HOUSING ACT.

AT the present moment Mr. Chaplin is carrying through the Commons an amending Bill to the Housing of the Working Classes, 1890. Upon the occasion of the introduction of that measure we condemned his measure as offering a "feeble, inadequate, and unsatisfying compromise, embodying the worst defects of patchwork legislation." As set forth clearly in the leading columns of THE MEDICAL PRESS AND CIRCULAR for Feb. 28th of this year, Mr. Chaplin's proposals amounted practically to two extensions. First, he proposed to grant local authorities power to acquire land for housing displaced population outside their own districts; secondly, he desired to simplify procedure in rural districts by dispensing with the necessity of approval of the Local Government Board, and substituting that of County Councils. These scant amendments could hardly be accepted as a statesmanlike treatment of an Act which we took the liberty of describing as well-nigh unrivalled for confusion, complication, and inadequacy. The reception of Mr. Chaplin's legislative effort by the House has shown that half measures of the kind he has advanced are not likely to pass into law in their present imperfect form. It may be said of the 1890 Act as it stands that it is so cumbrous and

costly in action as to be practically a dead letter with medical officers of health, excepting a limited application of Part II. In practice they have found that it is in every way easier and more advantageous to close insanitary dwellings under the Public Health Acts. The inadequacy of Part II. of the Housing Act as regards demolition has been proved to the hilt by a recent decision affecting some slum property in the parish of St. George the Martyr, Southwark. The history of the houses in question is so instructive, and at the present juncture so opportune, that there need be no apology for giving a bird's-eye view of the whole matter. In March, 1895, certain houses in Red Cow Alley, Tabard Street, were closed by order of the Vestry on the representation of the Medical Officer of Health, Dr. Waldo, that they were unfit for human habitation. In October, 1898, these dwellings still remained closed, and the Medical Officer reported "their continuance in that state is, in my opinion, dangerous and injurious to the health of the public and of the inhabitants of the neighbouring dwelling-houses." Accordingly, acting on his advice, in November, 1898, the Vestry of St. George's obtained a magistrate's order under the Housing Act for the demolition of the Red Cow Alley premises. Then followed a protracted and costly litigation, the earnest study of which may be commended to every Member of Parliament who wishes to advance the excellent principle of landlord's sanitary responsibility that underlies the Act of 1890. When the demolition order was served the owners of the property appealed to the Court of Quarter Sessions, and their appeal was heard in January, 1899. The insanitary state of the premises was then proved to the satisfaction of the court, and the order was sustained. The appellants, however, raised the technical objection that the words "dwelling-house" in the Act meant an "inhabited" dwelling-house, and only so much of the buildings could be ordered to be demolished as was dangerous to the health of the neighbourhood. On the strength of this objection the owners were allowed to appeal to the High Court, where their case was heard by Mr. Justices Ridley and Darling in November, 1899. The result was that the case was sent back to Quarter Sessions to determine whether the whole or what part of the premises was dangerous to the health of the neighbourhood. In January, 1900, this much-tried dispute came once again before the Court of Quarter Sessions, when the owners stated that certain parts of the premises had been demolished and the drains sealed. The action then reported, however, was not satisfactory to the Vestry, and the case was adjourned. The magistrate, Mr. Loveland-Loveland, then inspected the premises with some experts, whose names were not disclosed. The final decision has since been given. It is to the effect that the Court will not order any further demolition (the closets having been removed and the drains sealed), and directs each party to pay its own costs. The effects of a decision of this kind is to discourage local authorities

from any attempt to abolish insanitary premises from their districts. Nothing could have been worse than the Red Cow Alley slum dwellings, yet it has taken five years of intricate and costly proceedings to show that the owners of those houses "unfit for human habitation," could snap their fingers at the demolition provided for in the Housing Act. From the last decision there is no appeal so that these foul and ruinous dwellings may possibly linger on to another generation as a standing monument of ill-drafted and ineffectual legislation. No wonder that the local newspapers discuss the situation under the title of a "judicial scandal." One assertion that has been freely made is that the chairman of the Quarter Sessions who heard the case, and who gave the final decision, is himself a trustee of small properties in the Parish of St. George the Martyr. Even were that the case, it is impossible to countenance for a moment the unworthy suggestion that his judgment could have been influenced in any way by that connection. At the same time there is a wise unwritten rule that keeps a judge from adjudicating upon matters in which he may financially be interested.

RECOVERY OF FEES FROM HOSPITAL PAYING PATIENTS.

A HIGHLY important case was decided last Saturday in the Dublin Law Courts by Mr. Justice Madden and a special jury, in which an action was brought by Mr. Patrick Hayes, Surgeon to the Mater Misericordiarum Hospital, against a Mr. McHugh, of Strokestown, to recover his fees to the amount of £73 10s. for amputation of the defendant's leg, and for subsequent attendance. The patient must have been well able to pay, inasmuch as he received the injury in the hunting field, but he refused to give a sixpence beyond the £2 per week charged by the Hospital authorities for his maintenance though he received Mr. Hayes's services for nearly two months. His counsel argued that, if any one retained Mr. Hayes's services it was the Governors of the Hospital, and that it was his duty, as surgeon to the institution, to give those services for the inclusive payment of £2 a week. At the conclusion of the evidence Mr. O'Shaughnessy, Q.C. for the defendant, asked for a direction, on the ground that there was no contract entered into by the defendant or any agent on his behalf, with the plaintiff for remuneration. Mr. Justice Madden allowed the case to go to the jury. His lordship, in summing up, said he was glad to know that in future no similar case could arise to the Mater Hospital because they had separated physically the paying from the non-paying part of the institution. He left the following questions to the jury:—1. Was the plaintiff employed by the defendant to perform the operation for remuneration; (2) if so, to what remuneration is plaintiff entitled? The jury, after about half-an-hour's deliberation, answered the first question in the affirmative, and awarded plaintiff £50. Mr. Justice Madden granted a stay of execution for a fortnight. So far as this decision can rule, the point it appears

that the services of the Medical Officer of an hospital are not, in law, included in the sum paid for the patients maintenance. Indeed, it would seem ridiculous that any other view should be entertained, but we know that, quite recently, an agitation promoted by the Workhouse Medical Officers of Ireland have landed the whole of them in that position by introducing a clause to such effect into the Local Government Act. As a matter of fact any farmer or shopkeeper in the Union can now obtain admission to the workhouse hospital as a quasi-pauper, and there receive the best services of the Medical Officer but for which, however, the Guardians cannot make him pay a farthing. We strongly suspect, however, that substantial payments are made *sub rosa*, a system which cannot be too strongly condemned. In fact the whole business of prostituting the accommodation provided for the relief of the poor to the use of the well-to-do is a gross abuse and is corrupt in principle and in practice, and we cannot pity physicians or surgeons who lend themselves to the system if they are made the victims of mean and unscrupulous persons.

Notes on Current Topics.

Removal of the Gasserian Ganglion in Refractory Neuralgia.

PARTICULAR attention has lately been directed to the operation of removing the Gasserian ganglion for the relief of obstinate trigeminal neuralgia. At the Medical Society of London on Monday, Mr. Jonathan Hutchinson, jr., read a paper on the subject, giving details of a series of cases, and there have just been published accounts of the experiences and methods of W. W. Keen, of Philadelphia, and of H. Cushing, of Baltimore, in dealing with this procedure. In the course of some comments on the twenty-one cases of excision of the Gasserian ganglion that he has performed, Mr. Horsley lately remarked on several interesting points in connection with this operation. When approached from the outside the ganglion can be exposed in the *cavum Meckelii* by lifting the temporo-sphenoidal lobe and making a horizontal cut through the *dura mater*, but great difficulty may be met with at this juncture from hæmorrhage. Emissary veins cross from the cavernous sinus on the inner aspect of the field of operation, and are liable to injury on the adhesions usually present with trigeminal neuralgia being separated; it is a matter of some importance as the black venous blood may obscure the view. Arterial bleeding may also have to be dealt with arising from one of the lateral branches of the basilar artery supplying the ganglion. Though somewhat embarrassing the hæmorrhage can be controlled by suitable pressure with long probes. In Mr. Horsley's opinion particular attention should be directed to steadily applying traction to the sensory root of the ganglion, so that it be drawn away from its attachment to the pons. From his experience Mr. Horsley considered that there was very little risk to life from the

operation itself. Great care has to be exercised in preparing the cases for operation, the eye on the side affected is washed out two days before with boracic acid lotion, and the ear cleansed with carbolic acid and boracic powder. The side of the head is shaved, and treated in the usual manner with turpentine, perchloride and carbolic acid. With reference to the danger to the eye on the side the neuralgia occurs, strict adherence to the following rules of treatment prevents any fear of conjunctivitis associated with a corneal ulcer leading to perforation. The eyelids should be stitched together temporarily with horse-hair, and a sheath of gutta serena should be fastened at the outer canthus of the eye so that no antiseptic gets forward to irritate the conjunctiva. The successful nature of the procedure is indicated by the fact that in Mr. Horsley's series of cases recurrence has not taken place.

The Skipping-Rope Sensation.

THE latest journalistic sensation is the use of the skipping-rope as an aid to health. A Birmingham paper announced that the latest fad for stimulating torpid livers was skipping, and that middle-aged residents in the Midlands, both male and female, had taken up the pursuit with enthusiasm. This statement has stimulated the imagination of journalists all over the United Kingdom, and the public is being deluged with paragraphs on the subject. One newspaper writer trembles at the thought of what may happen should this particular kind of liver exercise become fashionable in the jerry-built flats of modern London. He goes on to picture an eighteen-stone lady or gentleman performing in the room over one's head, and has called in the aid of a pictorial artist to depict a breakfast table bombarded with fragments of a ceiling that has collapsed under the circumstances named. Seriously, there can be little doubt that skipping is an excellent kind of exercise for the liver, just as riding, rowing, tennis, golf, fencing, and many other kinds of active exercise are calculated to benefit that much abused and long-suffering organ. At the same time it may be most emphatically stated that the skipping-rope would be not only unsuitable but absolutely dangerous to all weakly, stout, and elderly people. Skipping-ropes are excellent things for children, but grown-up folk can find far more reasonable excuses for taking exercise. The risks of ruptured tendons and fractured bones in old persons who took to skipping would be both instant and constant.

Improved Health of the British Navy.

THE forty-fourth annual report of the Missions to Seamen Society is an interesting document. It reminds us that sanitation is not everything in raising the standards of health and longevity, but that moral influences also play a considerable part in the upward movement. The Russian war, so it states, was the turning point for the better in much that affects figures, a statement that is borne out by some remarkable statistics. In 1856, the death-rate from disease was 12.1 per 1,000 as against 3.56 per 1,000 sailors

employed in the Royal Navy in 1898. The actual deaths from disease in the latter year amounted to 295, which shows no less than 700 lives saved in a single year by the lessened ratio of mortality since the Crimean war. The Medical Director-General's reports show a great diminution of venereal diseases, which formerly sapped the strength of the Navy. In the early sixties some ships of the Channel Squadron had more than 100 men of their crews laid up at a time for the most part from the cause mentioned, while the naval hospitals were crowded with patients suffering in a similar way. The marked improvement of recent years is due to a better moral tone both among officers and crew, and to the spread of enlightenment and education among the men. There can be no doubt that much excellent work has been done by the Missions to Seamen and kindred societies. At the same time one should not forget that a vast deal has been effected in the last half century in improving the diet, the quarters, and the general environment of the man-o'-war's man, while the scientific treatment of disease has made corresponding advances.

The Alleged Poisoning of the Boer Bullets.

A GREAT deal of discussion has recently taken place in the lay press regarding the alleged poisoning by the Boers of the bullets used by them in the war. It was, therefore, quite natural that Mr. Treves, in his excellent and interesting address before the Royal Medical and Chirurgical Society last week, should allude to the matter. He stated that he had had the green coloured deposit upon the Boer bullets, which had been said to be dipped in verdigris, analysed by Mr. Candy at the London Hospital, and the report was that the green material was absolutely non-poisonous. The basis of the compound is paraffin, and the colour is due to an oxide of nickel, and the probability is that the substance used by the Boers was for the purpose of keeping the barrel of the rifle free from fouling—curiously enough, however, two days after this announcement had found its way into the lay press, another report upon the same subject appeared, and this emanated from the Chemical Laboratory of Her Majesty's Dockyard at Portsmouth. The report was to the effect that the bullets had been deliberately poisoned, and that "a mixture of acetate with verdigris had been added to molten paraffin wax and thoroughly incorporated, and the bullet coated with the compound." So runs the report, and although it is somewhat indefinite its meaning, nevertheless, is clear, namely, that the bullets contain a poison which has been added to them intentionally. The interest which belongs to these two opinions is—*which of them is correct?* It is difficult to believe that both could be right. However, both agree upon the matter of the paraffin base, and this being the case, the probability is that the divergence of opinion is to be accounted for by some inadvertent error in conducting the analysis by the one or the other analyst. Inasmuch, then, as the point is really an important one, we think that it should not be allowed to rest where it is. The Government

should take steps to ascertain definitely whether the bullets are really poisoned or not.

The Value of Commonplace Medicine.

It is too much the fashion nowadays to run after new things and to worship at every fashionable shrine of novelty to the exclusion of matters of everyday experience in practice; while it is desirable for the student as well as the practitioner to keep abreast of the main points of advance professional, yet he will find that life is too short to allow of anything like a comprehensive grasp of the whole subject. The everyday work of the medical man engaged in general practice brings him into contact with a hundred and one commonplace maladies, the proper recognition and treatment of which will bring him both reputation and financial competency. Hence it is sound advice to the student to devote a great deal of careful attention to such cases as pneumonia, bronchitis, hemiplegia, heart and kidney troubles, dyspepsia, rheumatism and gout, wounds, fractures and dislocations, all things he is certain to be called upon to treat constantly in after life. The study of such complaints can be best performed in the wards, and one single case of the kind conscientiously followed up is worth more than a half perception of a score of rare conditions. It is a pity that those responsible for the methods of medical education are not more alive to the fact that the student of to-day is to become the practitioner of to-morrow, with his own reputation and livelihood and the welfare of his patients at stake. It would be well for every student of medicine to acquire a clear perception of the value of the commonplace in his education.

A Remarkable Circular.

OUR attention has been drawn to a circular of a somewhat extraordinary character issued by Lieut.-Colonel Evans Gordon. It is dated from Cliftonville, and states that the gentleman in question having a large house is prepared to receive delicate children. The reason given for his "enforced residence" in Margate is that he was "driven thither" by the illness of his little girl. "She was operated on for glands," says the circular, "both by Mr. Frederick Treves, in London, and by Mr. W. K. Treves, in Margate. Both these gentlemen gave it as their opinion that the only chance for a perfect recovery lay in a three years' residence in Margate." The gallant Colonel encloses with this document a visiting card bearing the address of the Army and Navy Club, a proceeding that does not strike one as being strictly in accordance with the somewhat rigid code of social ethics observed at institutions of the kind. Nor can he be congratulated on his treatment of the unwritten laws which with a somewhat vacillating sceptre guide and govern the medical profession. Anything more startling in its way than the broadcast distribution of the surgical performances and opinions of the two surgeons described in the above quotation has not appeared above the medical horizon for some time past. It is needless to say that the two gentlemen thus singled out for observation would

be the last persons in the world to desire such invidious distinction. The error appears to have been due to a curious want of knowledge of the world and anxiety to make out a good case for himself on the part of an injudicious army man.

Intestinal Worms in Korea.

ONE of the notable results of the general improvement in the water supply throughout the United Kingdom has shown itself in the diminution of intestinal worms. Indeed, many practitioners in towns rarely meet with cases of tapeworm and *ascaris lumbricoides*, and then only in persons who have been exposed to infection in country districts. In the *Canadian Journal* a recent writer upon disease in Korea, Dr. Avison, has drawn a graphic picture of the close relationship between polluted drinking water and intestinal worms. Korean communities, it appears, are content to leave all drainage to open gutters which run alongside the houses, and are common conduits for all house and street refuse, flushing being left to rainfall. The water closets jut out from the sides of the houses so as to overhang these gutters, and the night-soil drops into them and forms one of the most striking of the street scenes and odours to the newly arrived foreigner. One peculiarity is the constant presence in the dejecta of tapeworms and *ascarides*, "so that one is almost forced to the conclusion that practically all Koreans are, during a great part of their lives, the hosts of these more or less troublesome intruders. The wells of the neighbourhood are usually shallow and placed within a few feet of the gutters. A more simple illustration of infection of the alimentary tract by the ova of the intestinal parasites conveyed in drinking water could hardly be imagined. As one might expect there is a brisk trade in vermicide remedies, of which santonin and extract of male fern appear to be most popular.

The Irrepressible Miss Beatty.

MISS BEATTY—the nurse whose name will be well remembered by reason of her ungrateful conduct towards Dr. Cullingworth in bringing action after action against him in respect of an operation which he had performed on her, according to the jury, with her implied consent, seems determined to keep her name before the public. For reasons best known to herself she thought well some time since to seek medical advice at King's College Hospital; but, as might be anticipated in respect of an applicant with such a litigious history, she was refused admission. Apart from the question whether Miss Beatty really belongs to the class of the "indigent poor" for whose benefit the hospital was founded, we are not aware that any obligation is imposed on members of the medical staff to attend patients to whose presence they object. Their refusal would, of course, expose them to the contingency of having to explain their position to the governing body of the hospital, but certainly not to any other body or person. In spite, therefore, of friends, in Parliament and outside, the aggrieved lady has been unable to obtain satisfaction

or revenge; in fact, as stated by the Attorney-General, so far as he is aware, "no legal obligation exists obliging such institutions to admit any particular individual," and even if there were it would be difficult to bring compulsion to bear on the particular medical officer.

Studies in Iodoform.

THE marked action of iodoform in restraining suppuration and in bringing about the cicatrisation of tuberculous abscesses and the like, though generally recognised, has not so far been satisfactorily explained. It was long ago shown that its antiseptic action was small, prolonged exposure to the vapour being required to kill streptococci, &c. In contact with suppurating tissues iodoform is said to be decomposed, iodine being set free, but as a matter of fact, even when decomposed, its germicidal action is comparatively feeble. Professor Cornil, of Paris, publishes some interesting results of experiments carried out under his direction with the object of ascertaining the action of the drug on normal tissues. Briefly stated, the action of iodoform on the peritoneum, and on serous membranes generally, is to set up a definite degree of inflammation accompanied by destruction of the fixed cells in contact therewith and an increase in the number of leucocytes, effects which are not peculiar to iodoform, but follow the use of any irritant, such, for instance, as weak solutions of nitrate of silver. It is thus shown that iodoform acts on the micro-organisms on the one hand, and on the tissues on the other, but we are not yet in a position to decide to which of the two actions its valuable properties are due.

The Contagion of Insanity.

THE use of the term "contagion" as applied to insanity is, of course, merely a convenient figure of speech, intended to express the fact that some cases of insanity arise from prolonged intercourse with insane patients. That such a thing happens has long been recognised by authorities upon mental disease. Indeed, there is no more rooted popular belief concerning madmen than that which attributes an undue proportion of instability to medical officers and attendants in lunatic asylums. The origin of the trouble may be to a certain extent mimetic, for it is certain that the imitative faculty is more or less actively at work at all ages and stages of the brain of that highly complex animal man. In other words, the two chief factors concerned in "contagious" or "mimetic" insanity, are sympathy and suggestion. So long as the individual exposed to such influences maintains a good standard of bodily health he is likely to escape any serious consequences. It is only when the powers of mental resistance are weakened by impaired nutrition or other physical injury that the brain gives way. Fortunately, the prognosis is good in cases where there is no family predisposition towards mental trouble. A prolonged absence of the sufferer from the insane environment is sufficient in most cases to effect a cure. One practical moral to be drawn from a consideration of this

aspect of lunacy, is the absolute necessity for a liberal and regular allowance of holiday for everyone engaged in the care of the insane.

Non-Expert Evidence of Drunkenness.

THE question of the value of non-expert evidence as to intoxication is one of interest to every inhabitant of the United Kingdom, inasmuch as everyone is liable to those conditions of unconsciousness which are commonly mistaken for alcoholic coma. Only last week a case was reported of a man taken out of the police cells, where he had been lodged as drunk and incapable, to die of apoplexy in the wards of a hospital. Hardly a week passes, indeed, that some terrible story of the kind does not come to light, to say nothing of many that are doubtless hushed up. Some of these cases could be sifted out by an intelligent constable or police superintendent who had been well coached up on the subject by a good ambulance instructor. However, the fact remains, that a certain percentage of cases are overlooked by qualified medical men, police surgeons, and others, who are called in to decide the question and who fail to detect, say, a fractured base, or a cerebral hæmorrhage, or a diabetic coma. The plain fact of the matter is, that whereas the average man in the street can detect with absolute accuracy the early and ordinary signs of drunkenness, on the other hand any such determination in cases of profound unconsciousness is at times one of the hardest problems with which an experienced medical man may be confronted. In the latter class of case, therefore, non-expert evidence should be regarded with the utmost caution, for the fallacy of such untutored opinion is almost daily demonstrated by the tragic histories of our police-stations. As to the ordinary acts that characterise the excitant and inco-ordinate stages of alcoholic poisoning there seems to be no particular reason why non-expert evidence should be excluded.

"The Plague of Women."

DESPITE the acrimonious outcry which followed the allegation that "society" women were masquerading as trained nurses in South Africa, it was commonly felt that the women had constituted themselves a plague. Since then the evidence upon this point has been accumulating, and an Army nurse writing to a contemporary last week very plainly shows what a plague these society women have been. "No end of trouble," she says, "has been caused by these masquerade nurses to doctors, nurses, and poor sick, wounded Tommies. They get in everybody's way, and have no intention of working. Their idea is to take posts of authority, and 'boss' the trained nurses who have borne the heat and burden of many years in hospital." This is only a part of the picture which she draws of the harm thus caused to the sick and wounded. But the inconceivable feature in the matter is that the women were able to obtain the appointments as nurses through social influence; that is to say, that the military authorities conceded the demands merely because they happened to be made by persons "in society." We

are glad that Mr. Treves has had the fearlessness to show the British public that "society" cannot have their own way always, without bringing upon themselves the condemnation of all right-minded citizens.

The Coming Session of the General Medical Council.

THE Council re-opens its doors on the 22nd of this month and is likely to have a prolonged and busy session in which many most important questions will be discussed. Outside educational questions, which always occupy most of the time of the Council, the subject of reciprocity of practice with foreign nations, raised by the Italian Government, will be debated, as also the means to be taken to prevent personation of a deceased practitioner. The Midwives' Bill will also, without doubt, arouse considerably controversy; and the finances of the Irish Branch Council will have to be adjusted. One of the most important educational subjects before the Council will be the *impasse* which has been created by the determination of the London colleges to force grammar schools into the educational arena of the profession. The Council, by an enormous majority, has already protested against any such proposition, but the colleges are recalcitrant and bellicose and will need to be dealt with by a strong hand.

The Coming Council Election at the Royal College of Surgeons, Ireland.

As the first Monday in June approaches numerous candidates for seats from among the Fellows outside the Council are presenting their claims to the honour. Mr. Conway Dwyer, of Jervis Street Hospital, lately Examiner in Surgery in the College, has sent round his cards. Mr. Graves Stoker, Surgeon to the Whitworth Hospital, Drumcondra, and Mr. J. D. Hillis, Surgeon to the Throat and Ear Hospital, are also candidates. Mr. Saunderson Morrison, of Dundalk, takes up special ground, urging his claim as a provincial representative, and as independent of all school interests. He was a competitor at the last election. Many names must, no doubt, be added to this list before the election day arrives.

The Notification of Measles.

IN a moment of enthusiasm the Newquay (Cornwall) Urban District Council placed measles on the schedule of diseases to be notified but an outbreak of the disease, comprising some 150 cases, has made them regret their action, and an application is to be made to the Local Government Board for permission to withdraw measles from the list. This is regrettable, coming as it does at a time when the necessity for measures to prevent the propagation of this eminently contagious, and, in the aggregate, fatal disease, is gradually obtaining recognition. We may remind them that measles is anything but a mild disease, the deaths from this cause accounting for nearly one half of the total mortality from zymotic diseases in this country.

The Midwives Bill.

As we have already stated, the Report stage of this Bill, upon which much will depend, cannot be taken before June 27th. It is necessary, however, to provide, by resolution of the House of Commons, for the payment of the expenses of carrying it into effect, if passed, because no such proviso can be inserted in a Bill. The necessary resolution was on the paper last week, but was adjourned, on the motion of Sir Walter Foster, after the naïve confession by the Leader of the House that "he knew nothing of midwives' expenses." It is interesting, meanwhile, to observe that the midwife "profession" in Finland is to hold a congress at Helsingfors next month. A meeting of the aggressive and pugnacious Manchester local branch of the British Medical Association has been called to consider and determine the attitude to be adopted towards this Bill. Dr. Arthur Helme has given notice that he will move the following resolution:—"That the Lancashire and Cheshire Branch of the British Medical Association is of opinion that the Midwives Bill, as amended by the Standing Committee on Law, and at present before Parliament, if it became law would be a direct danger to the public safety, seeing that it does not provide for the following essential points: 1. Definition of midwife: this must (a) impose attendance after, as well as during labour; and (b) restrict her practice to natural labour. 2. Statutory penalty for practice as well as for assumption of title by uncertified persons. 3. Statutory penalty for malpractice or misconduct. 4. Constitution of Midwives Board: necessity for direct (district) representation of medical practitioners. 5. Statutory obligation for midwife to summon medical aid in case of abnormal labour or disease of, or danger to, mother or child. 6. Necessity of direct medical supervision of midwives. 7. Necessity for prevention of employment of uncertified substitutes during labour or the lying-in period. 8. Necessity for control over lying-in homes."

Retirement of a Veteran Hospital Physician.

THE retirement of Dr. John Cameron from the Royal Southern Hospital, Liverpool, is an event that calls for mention. Appointed to the post over 52 years ago, he has laboured there with a devotion and unity of purpose that deserve the highest commendation. It is not too much to say that Dr. Cameron has spent a long life entirely in the interests of his patients, and the profession at large. In Liverpool he has long been looked up to as an embodiment of the ideal physician, lofty-minded, deeply read, highly trained, and possessed of all the attributes that must lead to prominence and a front rank in whatever walk in life their possessor selects to follow. In the words of a leader in the *Liverpool Courier* on the subject: "Dr. Cameron has always been an active member of the community, taking a keen interest in all that appertains to its intellectual progress, the medical side having been, as was natural, strongly favoured by him. With such a splendid record of public work taken in connection with a Liverpool medical charity—honorary so far as fees are concerned, but onerous

in its demands upon his time and skill—it is but fitting that on his retirement he should receive, not only the formal thanks of the committee of the hospital and the deep gratitude of the patients who have received his attention, but also this public reference to a career highly honourable to himself and to his profession, as it has been greatly advantageous to the community of which he is a member." We heartily wish him a long life and a green old age, and a complete recovery from the attack of influenza which has brought about his retirement, and from which he is rallying only with difficulty.

A Troublesome Patient.

It is always a disagreeable task to constrain an ungrateful patient to discharge the liabilities which he has incurred; still more so when, as is usually the case, the defence is based on allegations of neglect or malpraxis. Messrs. Anderson and Fenner, who practise in the neighbourhood of Cavendish Square, had, however, the courage last week to seek to enforce payment from a Mr. Moeller, a patient who had given them a vast amount of trouble, not only by reason of the nature of his disease, but also on account of his nervous, hysterical temperament. Mr. Moeller, it seems, was suffering from an obscure form of streptococcus poisoning, simulating articular rheumatism, which, for convenience, Dr. Anderson had described to a relative as "rheumatic gout." There is no doubt that the patient was very ill, and that his nervous system suffered from the effects of a protracted and painful malady; but with every sympathy for him in his sufferings we are unable to find any ground for disputing the bill which he thought "exorbitant" coming from general practitioners, as though general practice imposed dispensary fees on those who devote themselves to this, the most laborious and exacting department of medical practice. Dr. Anderson and Mr. Fenner are to be congratulated on having obtained a verdict which not only exonerates them from the charges of ignorance so liberally dispensed by the defendant's counsel, but also condemns Mr. Moeller to pay their bill. So far as one can gather from the published reports there was not a shadow of evidence that the medical plaintiffs failed to diagnose the disease, although it was not of an every-day sort, and certainly the treatment was *secundum artem*.

No Ladies Need Apply.

THE Shepton Mallet Board of Guardians evidently hold the old-fashioned prejudice against women doctors for, on a recent occasion, they declined to accept the services of Miss Glynn, though fully qualified, as deputy for Mr. Fry, their Medical Officer.

THE estate has been valued at £151,094 10s. 2d. of Sir William Overend Priestley, of 17, Hertford Street, Mayfair, M.D., LL.D., M.P. for Edinburgh and St. Andrews Universities from 1896, who died on April 11th last, aged 70 years.

DR. J. SINCLAIR, Medical Officer of the Slaidburn

district of the Clitheroe Union, has poisoned himself by, it is supposed, taking an overdose of arsenic.

PERSONAL.

MESSESS. ROTHSCHILD AND SONS have subscribed £500 to the Prince of Wales's Hospital Fund.

DR. GLASCOTT has succeeded Dr. Little as Lecturer on Ophthalmology at The Owens College, Manchester.

MR. J. BLAND SUTTON, F.R.C.S., is a candidate for a seat on the Council of the Royal College of Surgeons of England.

MR. WILLIAM TAYLOR has been appointed surgeon to the Meath Hospital and County Dublin Infirmary, *vice* Dr. R. Glasgow Patteson, deceased.

MR. G. C. LOW, M.A., M.B., a student of the London School of Tropical Medicine, has been awarded the Craggs Research Scholarship, worth £300 per annum.

DR. A. J. HARRISON will deliver the presidential address at the annual meeting of the Dermatological Society of Great Britain and Ireland, on Thursday, May 24th.

DR. F. W. MOTT, the Pathologist to the London County Council, will deliver the Croonian Lectures before the Royal College of Physicians in June, on "The Degeneration of the Neuron."

DR. PORTER, Medical Officer of Health for Stockport, on leaving to take up his duties as Medical Officer of Health for Salop, has been the recipient of several tokens of appreciation from the Corporation, staff, and practitioners of the district.

THE late Professor Tarnier, of Paris, has bequeathed funds bringing in some £200 interest per annum, a large portion of which is to be devoted to an annual prize, to be awarded to the author of the best work on obstetrics or gynaecology.

MUCH sympathy is felt Professor Leech who is prevented by serious illness from taking his usual classes in *Materia Medica* at Owens College, Manchester, and will, it is feared be unable to take his seat at the forthcoming meeting of the General Medical Council in London.

MR. FREDERICK TREVES has been offered the freedom of his native borough of Dorchester, a token that the worthy burgesses of that town share the appreciation generally expressed in regard to the valuable services which this eminent surgeon has rendered in South Africa.

FEW men living can lay claim to the record of having been actively attached to a hospital for 52 years. This was attained by Dr. John Cameron a few days since when he resigned his position (on account of advancing years) as honorary physician to the Royal Southern Hospital, Liverpool.

An Hospital on Fire.

EARLY on the morning of the 14th inst. the female ward of the Morecambe Isolation Hospital at Bare was discovered to be on fire. Two women and 20 children, who were nearly convalescent, were quickly removed to an adjacent building. The fire is believed to have originated in the stove flue. The hospital was of timber and corrugated iron, and was totally destroyed within an hour, only the bedding being saved.

Scotland.

[FROM OUR OWN CORRESPONDENT.]

SMALL-POX AND LADY MEDICAL STUDENTS.—The students of Queen Margaret College are very much elated at the present outbreak of small-pox which has for some weeks past been on the increase, as last year and the year previous a large number of students attending at the Fever Hospital were sadly disappointed, for in their search after knowledge they went there with the fixed purpose of facing the enemy, and, in order to be thoroughly prepared, they allowed re-vaccination to be done on them, hoping that kind fate would send at least one case of small-pox upon which they could gaze with pleasure and satisfaction. Fate, however, was against them, and they were doomed to sad disappointment, at least for the time being. Now, however, they are reaping the reward of their forethought in being re-vaccinated, and have the satisfaction of gazing upon and studying from no less than 28 cases in all the different stages of the disease as they are to be seen in the wards of Belvedere Hospital.

ALLEGED "PLAGUE" IN GLASGOW.—There has been a rumour, for which there is absolutely no foundation, that "the plague" had made its appearance in Glasgow. It may be stated as a fact that since the Sanitary Department of the Corporation was established there has never been even one solitary case of bubonic plague, much less an outbreak in the city. There are, however, no less than 28 cases of small-pox in the Fever Hospital, an increase of eight cases on the week previous, which have all been traced to one imported case, and every precaution is being taken to prevent further contagion. This outbreak of small-pox may have caused the report of the presence of plague in Glasgow to emanate from the London Stock Exchange. With all the care and attention of the Sanitary Department, we are sorry to say that both typhus and enteric fevers are on the increase, and, like scarlet fever, measles and the poor, will be always present with us.

FEVER HOSPITAL SUPERINTENDENT.—It is understood that the present superintendent of the Belvedere Fever Hospital is to be transferred to the new hospital at Ruchhill, and is to be recognized as Superintendent-General; consequently another superintendent will be required for Belvedere Hospital. At the outset the Corporation expressed their preference for an unmarried man, but this intention has been departed from, and married and single applicants can compete for the appointment. Of course, in all such appointments influence will carry the day in nine cases out of ten, and it will not be astonishing if an outsider is elected.

Manchester.

[FROM OUR OWN CORRESPONDENT.]

MEDICAL SCHOOL.—Work is in full swing. An increasing number of men are reading for the examinations of the Victoria University. The classes for the diploma in Public Health are much patronised. But little is arranged for post-graduate study; two classes, however, are to be conducted specially for advanced students and practitioners:—Dr. Steell on "Heart Affections," and Dr. Harris on "Lung Diseases." Much progress is being made in the building of the new Whitworth Hall. No solution of the Infirmary site difficulty has as yet been found.

CONFERENCE ON MEDICAL ORGANISATION.—The recent Conference held under the auspices of the Medical Guild gave ample opportunities for the indication of many well recognised grievances. The lack, however, of a sufficiently representative character prevented the adoption of any adequate measures for organisation of the profession. Resolutions were passed approving the formation of local or district associations for the discussion of medico-ethical and medico-political topics, an annual conference of delegates from such associations, and a central executive committee. The need for con-

centration was insisted on, and the view expressed that attempts should be made to "convert" the "British Medical Association into an energetic body really representative of the majority of the members of the profession."

PATHOLOGICAL SOCIETY.—At the last meeting of this Society, Professor Trevelyan, of Leeds, gave an important communication on "Combined Valvular Lesions of the Heart," illustrated by a number of special preparations.

MEDICAL SOCIETY OF LONDON.

At the meeting on Monday evening last (May 14), the last of the session, Mr. Hutchinson, junior, read a paper on Excision of the Gasserian Ganglion for Epileptiform Neuralgia of the fifth nerve, and he narrated a series of cases in which he had performed the Hartley-Krause operation, by trephining through the floor of the temporal fossa, and lifting up the dura mater and temporo-sphenoidal lobe. In only one case did the cornea undergo destructive ulceration, and this patient had suffered from conjunctivitis before the operation. He urged that this method was the only one by which the ganglion could be really exposed. He thought it probable that intracranial division of the superior maxillary nerve would supersede the so-called excision of Meckel's ganglion in cases of neuralgia confined to the upper maxillary division, and urged that excision of the Gasserian ganglion should be resorted to in cases of inveterate neuralgia of the fifth nerve in preference to a series of palliative measures on its branches before the patients were completely worn out by pain and want of rest. The deformity left was very trifling.

The President (Dr. F. Roberts) regretted that some other term than neuralgia could not be used to distinguish cases of pure neuralgia from those in which there was an organic base, and Dr. Sansom concurred in this view.

Mr. Hutchinson, in reply, admitted that it would be convenient to differentiate between the organic cases and the others, but so far no pathological data were available which would allow of their doing so.

The next paper was one by Dr. Alexander Morison on a case of Malignant Endocarditis, in which both the mitral and aortic valves were extensively diseased, in which on auscultation the cardiac sounds were as a rule clear. This led him to discuss the causation of the first sound of the heart, which he considered arose chiefly in the right ventricle.

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

APOSTOLI'S ELECTRICAL TREATMENT OF UTERINE FIBROIDS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In a short paragraph recording the death of Dr. Apostoli, two errors appear. The first is evidently a slip, as the treatment is spoken of as the "electrolysis" of fibroid tumours.

The second lies in the words "now discredited." Was it ever anything but discredited here in London? I remember hearing the subject debated, I could not call it discussed, by the Obstetrical Society some ten or eleven years ago. The treatment was condemned of course, apparently without much trial.

One well-known teacher of obstetrics has shown us lately that the mortality after hysterectomy in three London teaching hospitals is 25 per cent., and this for a disease which, he says, very rarely kills if left alone. If the London teachers of obstetrics are satisfied with surgery such as this, no wonder they have always discredited a treatment which is not brilliant and which can only show a woman in health, with, in most cases, more or less of a fibroid, rather than a dead woman whose friends have the satisfaction of knowing that though she died the operation was perfectly successful as the growth was removed!

The electrical treatment of fibroid tumours continues to cure patients, but it could have done nothing for the lady from whom I lately removed a fibro-cystic tumour of 36 lbs. in weight, not only to her friends' satisfaction, but also to her own. Electricity can cure most cases, but if it did so only in 75 per cent., the remaining 25 would be in their coffins.

I am, Sir, yours truly,

SKENE KEITH,
Charles Street, Berkeley Square, London, W.,
May 13th, 1900.

CONGENITAL LARYNGEAL OBSTRUCTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Mr. Lennox Browne, in a letter to you under the above heading, states that he is not quite clear as to the views I have expressed as to the pathology of congenital laryngeal obstruction and other allied affections. He has quoted statements of mine which appear to him contradictory. As this may mislead others, I venture to ask leave to make a short reply. Mr. Browne's confusion entirely arises from the fact that he confounds congenital laryngeal obstruction with laryngismus stridulus, and perhaps other forms of laryngeal stridor in infants.

Congenital laryngeal obstruction is a definite affection, the clinical symptoms of which have been thoroughly described by Dr. John Thomson (*Edin. Med. Journ.*, Sept., 1892), by Dr. Sutherland and myself (*Lancet*, 1897, ii., p. 651), and other authors. The correct pathology of this affection was first described by Dr. Sutherland and myself in the above-mentioned paper, as the result of laryngoscopic examination in a series of cases. We pointed out that the stridor was due to a definite deformity of the larynx and to valvular action of the superior laryngeal aperture. Since then this view has been disputed, chiefly by Dr. Eustace Smith, who holds that the disease is a laryngeal spasm due to adenoids. Now Dr. McIlraith's case was a typical one, and post-mortem the larynx presented the peculiar deformity I have described. The case, therefore, corroborates my observations that the disease depends on this laryngeal deformity. Dr. McIlraith's opinion that the child died of laryngeal spasm is no contrary argument. Spasm may or may not have been the cause of death; there is in any case no reason to suppose it was the cause of the previous symptoms.

I have shown that laryngeal deformity sufficient to cause the stridor is present in a series of these cases, that adenoids are absent in most of them (see also Dr. McBride, *Lancet*, June 8th, 1895), and, therefore, it is fair to assume that adenoids are never the cause of this form of laryngeal stridor, but Mr. Lennox Browne asserts that "laryngeal stridor—laryngismus stridulus—will often be found to be due to adenoids," and quotes among others a case of my own in support of this statement. There is no contradiction here; laryngismus stridulus and congenital laryngeal obstruction are entirely distinct affections, and it is really remarkable that any one of Mr. Brown's standing should confuse them. The differential diagnosis, although really unnecessary, was for the sake of completeness pointed out in the paper from which Mr. Browne quotes. Of course, there are many other causes of laryngeal obstruction in infants, and the affection variously known as congenital laryngeal stridor, infantile respiratory spasm (Thomson), and which in view of its pathology Dr. Sutherland and myself have preferred to term congenital laryngeal obstruction is only one of them.

I am, Sir, yours truly,

H. LAMBERT LACK.
48, Harley Street, W.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your last week's number a letter appears from Mr. Lennox Browne with reference to a case of the above nature shown by me at the Harveian Society. There are one or two points which occur therein, which, I think, require correction. In the first place the case was brought forward as one of a disease which I thought was recognised, but the pathology

of which was under discussion. It is a disease quite apart from laryngismus stridulus, and depends, as pointed out by Drs. Lack and Sutherland, on a malformation of the larynx, as was clearly evidenced in the specimen of the larynx shown to the society. Mr. Lennox Browne has evidently overlooked this fact, as plainly described in your issue of May 2nd, p. 447. He says: "In the exhibitor's opinion death was due to laryngeal spasm," and seems to see some discrepancy in this and in Drs. Lack and Sutherland's statement, "that the affection is in anyway a spasm seems to us untenable." I cannot see why death could not have occurred from a sudden tonic spasm of the larynx, as sometimes happens even in pertussis, &c., without presuming that the affection was a clonic spasm as, I believe, is the view that has been put forward by those who hold that the disease is of a spasmodic nature.

Again, Mr. Browne states "the spasm is described as congenital," again overlooking the fact that the malformation of the larynx was the congenital element in the case. The mechanical obstruction produced by this was, as I pointed out, sufficient to produce the symptoms seen during life, and was confirmatory of the appearances frequently observed clinically. To ignore an important point seems to me a very illogical way of gaining any "practical deductions."

The child had been under specific treatment for congenital syphilis as advised by Dr. Goodhart, but so far as the laryngeal symptoms were concerned had not improved thereby. This was mentioned at the meeting of the Harveian Society, but did not appear in the report.

Finally, with reference to adenoids, I beg to draw Mr. Lennox Browne's attention to what was actually said as reported correctly in your issue May 2nd, p. 448.

I am, Sir, yours truly,

CHARLES H. McILRAITH,

Herne Hill, London.

BOARD SCHOOL DIPHTHERIA.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—From the annotation on Board School Diphtheria in THE MEDICAL PRESS AND CIRCULAR of the 9th inst., it would appear that the same insanitary conditions exist in the school as existed when it was first built, some sixteen years ago. That, of course, is not the case. The school has, I believe, caused the Board great trouble and expense, and the whole playground has been raised so as to allow of a better system of drainage. What I meant to convey in my paper was this, namely, the manner in which diphtheria was set going in the district, from which it has never departed for any length of time.

Since the latest efforts of the Board with that particular school we have had fewer cases, and that I think points to the correctness of my observation.

I am, Sir, yours truly,

May 11th, 1900.

H. CAMPBELL POPE.

PROFESSIONAL SECRECY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In reference to the case before the Nottingham magistrates, referred to in your last issue, in which Dr. Hunter refused to state the nature of his patient's illness on the score that such evidence would be a breach of professional secrecy, may I be allowed to submit that the medical profession, as far as I am aware, has no prerogative in declining to give evidence beyond any ordinary witness.

The same "secrecy" and confidence exists, or should exist, between a solicitor and his client as between a medical man and his patient, and the question of refusing evidence in the former case has never, I believe, been taken exception to, why therefore should medical men refuse evidence which must necessarily impede the course of justice, and embarrass a court of law?

I am, Sir, yours truly,

CLEMENT H. SEES.

Queen's Road, Peckham, S.E.,
May 5th, 1900.

Obituary.

MR. J. N. COLLEY DAVIS-COLLEY, F.R.C.S.

THE death of Mr. John Neville Colley Davies-Colley, F.R.C.S., formerly Surgeon and Lecturer on Surgery to Guy's Hospital, occurred early last week, after an illness of several months' duration, at Borough Pulborough, Sussex, at the comparatively early age of 57. His father was the late Dr. Thomas Davies-Colley, M.R.C.P., consulting physician to the General Infirmary, Chester, in which town he was for many years engaged in general practice. Mr. Davies-Colley was educated at Cambridge University and Guy's Hospital. Early in his career he was appointed Demonstrator of Anatomy, Lecturer on Experimental Philosophy in the Medical School, and Surgical Registrar to Guy's Hospital; he was subsequently appointed Lecturer on Anatomy, Assistant-Surgeon, and, in 1880, on the resignation of the late Mr. Cooper Forster, full Surgeon and Lecturer on Surgery. He graduated M.A. at Cambridge in 1867, and the year following obtained the M.B. and M.C. He became a member of the Royal College of Surgeons in 1868, and was admitted a Fellow of the college two years later. Mr. Davies-Colley was subsequently appointed to the office of examiner in anatomy for the diplomas of the Conjoint Board and for the Fellowship, and he was also a member of the Council of the College of Surgeons. He also served the office of examiner in surgery for the prescribed term of years in the University of Cambridge and at the Royal College of Physicians. At the time of his death he was consulting surgeon to the Seaman's Hospital, Greenwich, a Fellow of the Royal Medico-Chirurgical, and a member of the Pathological and Clinical Societies. In December last, owing to ill-health, Mr. Davies-Colley was obliged to resign his appointment of lecturer on surgery at Guy's. About a fortnight ago an address, signed by upwards of 600 of the past and present students of Guy's Hospital, was presented to Mr. Davies-Colley expressive of gratitude and appreciation.

DR. GEORGE BIRD.

We regret to announce the death of Dr. George Bird, formerly of Welbeck Street, Cavendish Square, a stalwart representative of a former generation, who died at his residence at Hampstead, on the 4th inst., at the ripe age of 83, the immediate cause of death being influenza. For many years Dr. Bird did a large, although probably not a lucrative practice, numbering amongst his patients some of the best-known representatives of literature and art, such well-known dramatists as Toole, Irving, the Bancrofts, and Ellen Terry being among his intimate friends. He was associated with the production of Ringer's Therapeutics almost from the first, and imparted to the successive editions much of their literary merit. He was in his time a great athlete and was skilled as a boxer and fencer. It is entirely typical of the man that he learned to ride the bicycle when over 80 years of age. Only three days before his death we hear, on the authority of an old friend, that he was engaged in teaching a boy how to jump on the bicycle while running. His friend, Sir Richard Burtor, dedicated to him one of the volumes of his "Arabian Nights." He was well known in society, and his numerous friends will hear of his death with sincere regret.

Literature.

DISEASES OF THE BLOOD-FORMING ORGANS. (a)

THIS is an excellent work and worthy of being placed among the best text-books on blood diseases in modern times, written by an author with large experience and sound judgment. Before chemistry and the microscope this department in medicine lay unexplored as a vast desert of hypothesis. By patient industry, careful observation, and accurate records, we are now able with some show of reason to assign eight diseases to morbid

(a) "Anæmia and Diseases of the Blood-Forming Organs and Ductless Glands." By Byrom Bramwell, M.D., &c.

changes in these blood-forming glands, viz.: Chlorosis, pernicious anæmia, leucocythæmia, Hodgkin's disease, Addison's disease, myxœdema and cretinism, exophthalmic goitre, and acromegaly. In the volume before us, Dr. Bramwell discusses each of these diseases, historically, clinically, pathologically and therapeutically in a most scientific and masterly manner. It is contended that diabetes should have been included in this category, but considering the diversity of opinion on the subject the author has wisely omitted it at present from the list of blood diseases.

In the arrangement of the work the author commences with a general definition and classification of anæmia, which is a wide term when practically considered in a scientific arrangement of cytogenetic or cytolethrotic, spleno-medullary or lymphatic. Dr. Bramwell contents himself with primary and secondary anæmia; the former, when the bloodlessness is the most striking clinical and pathological feature of the case, the latter, when symptomatic or depending upon some other exhausting diseases as cancer, suppuration, Bright's disease, &c. To be really scientific in hæmatic nosology he is of opinion that anæmia should be divided into

1st. Cases due to cytolethrosis—blood destruction.

2nd. Cases due to cytogenesis—blood formation.

This classification implies a more accurate knowledge than we possess at the present time of how much of the blood is manufactured in the marrow of the bones, the spleen, and lymphatic glands, or how much is destroyed in the gastro-intestinal mucosa and spleen. Such a classification would point to a different form of treatment, as in the increased destruction of the red blood corpuscles iron would be contra-indicated. In health the destruction of the red blood corpuscles is sufficient to supply the necessary quantity of iron to the liver for functional purposes, which, if increased by excessive destruction, would produce a pethora of iron in the system. In health not more than 0.15 parts of a grain is absorbed in the 24 hours.

For the student in blood diseases a very instructive paragraph is devoted to the 12 points to be observed in the examination of the blood in health and disease, viz., naked eye appearance, number of red corpuscles, quantity of hæmoglobin, microscopic appearance, &c., &c. This will be found a valuable adjunct to such a comprehensive treatise for the busy worker who is not making analyses every day.

Chlorosis, which forms one of the group Oligochromæmia, may be due to any blemish in the organism surroundings and history, but Dr. Bramwell supports the theory put forward by many that tubercle predisposes to chlorosis. Though this may be accepted as a proximate cause, the immediate cause is admittedly due to an unusual strain thrown on the blood-forming organs at the period of puberty, when the function of menstruation is established.

The production of the pulmonary murmur, though variously expounded, is held by the author to be caused by a wave of hydræmic blood through a narrow orifice into a wider channel, and not a systolic mitral murmur propagated to the pulmonary area.

Pernicious anæmia, or gastro-intestinal hepatic anæmia, is according to one of the hypotheses due to a destruction of the red blood corpuscles from poison absorbed from the gastro-intestinal tract, and this argument is certainly sustained by a large quantity of iron found in the liver, which would class the disease in the hæmolytic type of blood diseases. The antithesis of this causation is equally well supported by physical evidence that the bone marrow is the primary source of the disease. Between these two extremes we are still left in doubt on the primary lesion, although the clinician has irrefragable indices to differentiate a distinct morbid entity by the reduction of red blood corpuscles, increase of colour index, or alteration in size and shape of red blood corpuscles, &c., &c. The writer, like many others who have applied themselves to the investigation and treatment of this disease, is a strong advocate of arsenic in the treatment which seems to have a temporary influence in checking the progress of the disease.

Leucocythæmia may be described as the obverse of pernicious anæmia in which the white blood corpuscles are increased in number both absolutely and relatively to the red blood corpuscles. There are three forms according to the site of the primary lesion, spleno-medullary, lymphatic, and polymorpho-nuclear. Here we come to a number of diseases so closely allied to one another that a differential diagnosis is a matter of supreme difficulty owing to the line of demarcation being so hard to describe. Leucocythæmia has many symptoms common to Hodgkin's disease, this again to Addison's disease, and Addison's disease to Grave's disease, although the primary lesion of the latter is supposed to reside in a functional disturbance of the nerve system. These diseases are discussed individually and critically examined, with many examples to elucidate the theories advanced as well as arguments against the older dogmas that existed before the present physical demonstrations.

Myxœdema and acromegaly are also examined at great length with the same thoroughness and accuracy as the other subjects, making the book an excellent repository of our present knowledge of the morbid changes that occur in the ductless glands. We can highly recommend it to every practitioner and student of medicine as a reference and class-book of the first order, and should be in the possession of every member of the profession who desire to keep pace with the progress and science of our art. It is well written and clearly arranged for immediate consultation. We can faithfully recommend it as an admirable work.

Medical News.

Presentation to Dr. Thomas Myles.

A COMMITTEE has been formed of some of the professional and personal friends of Dr. Myles, the Vice-President of the Royal College of Surgeons in Ireland, to promote the presentation to him of a testimonial in next June, on the occasion of his induction to the Presidential Chair of the college. The hon. secs. of the movement are Dr. Lane Joynt, of Dublin; Dr. Greer, of Newport, Monmouth; Dr. McCraith, of Liverpool; and Dr. Mitchell, of Belfast; and the treasurer is Dr. Corrigan, of Cardiff, any of whom will willingly receive subscriptions.

French Hospital and Dispensary.

THE annual dinner on behalf of the funds of this institution took place at the Hotel Cecil on Saturday evening last, His Excellency the French Ambassador in the chair, supported by the Lord Mayor and Sheriffs of the City of London and many representatives of the *corps diplomatique*, Sir Wm. MacCormac, who was present in his capacity of consulting surgeon to the hospital, received a most enthusiastic reception, and in his remarks he insisted on the excellence of the arrangements for the reception and treatment of the wounded. He suggested that foreign Governments might do worse than send delegates to inspect this department of the campaign to inspect and report thereon. It is satisfactory to learn that this cosmopolitan charity is now established on a sound financial basis, though a debt amounting to some £3,000 has been incurred in respect of the recently opened Convalescent Home at Brighton.

Conjoint Examinations by the Irish Colleges of Physicians and Surgeons.

THE following have passed the Final Examination:—

- (a) Passed in all Subjects.—R. A. Campbell, J. E. Hannigan, D. L. Harding, E. E. Townsend, H. G. Westropp.
- (b) Completed the Examination.—W. J. Anglim, B. Wm. Coffey, P. J. McGinn, J. H. O'Connell, J. F. Smyth, J. Verdon.
- (c) Medicine.—R. G. Mostyn.
- (d) Surgery.—A. T. Benson, A. D. Dunwoody, D. A. Faris, J. L. Gilmartin, R. A. Johnston, R. G. Mostyn, D. J. F. O'Donoghue, D. Power, A. B. Stephenson.
- (e) Mental Disease.—D. A. Faris, J. L. Gilmartin, R. A. Johnston, N. P. Kirby, J. D. S. O'Donoghue, D. Power.
- (f) Ophthalmology.—A. D. Dunwoody, D. A. Faris, F. C. Fowler, J. L. Gilmartin, R. A. Johnston, D. J. F. O'Donoghue, A. B. Stephenson.
- (g) Midwifery.—J. L. Gilmartin, R. A. Johnston, D. J. F. O'Donoghue.

The successful candidates will be admitted to the Licence of the Royal College of Surgeons on Thursday and to that of the Royal College of Physicians on Friday.

Notices to Correspondents, Short Letters, &c.

✎ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a distinctive signature or initials, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

MR. E. C. (Belfast).—We do not give advice in these columns. In your case we would say "do nothing."

D. P. H.—We know of no information of the nature available, except Professor Montenegro's official report to the Spanish Government on "The Plague," a translation of which has just made its appearance, by Dr. Monro. The English edition has, moreover, an advantage over the original Spanish, inasmuch as it embraces more recent experiments and results of investigations.

DR. WILLIAMS is thanked for his communication, about which we are making enquiries, and will report so soon as the necessary information is to hand.

OBBER-AMERGAT.—If our correspondent will write to the proprietor of Hotel Tirol, Innsbruck, Austria, he will receive printed directions, which our Continental correspondent tells us he had arranged specially for English visitors to the Passion Play.

THE ROYAL MEDICAL BENEVOLENT COLLEGE.

The annual general meeting of this college is announced in our advertisement columns to take place on the 25th inst., when the Right Honourable the Earl of Rosebery will be proposed as President. We hope there will be a large number of friends of this excellent Institution present on the occasion.

MR. A. E. R.—The information has not yet come to hand, we hope for it in time for our next issue.

SCOTSMAN.—The reference in last week's *Truth* to Sir John Battie "Juke" is obviously intended to apply to Sir John Battie Tuke—a name, one would have thought sufficiently well-known by this time to defy the printer's devil and all his works.

VACCINATION IN CONSTANTINOPLE.

VACCINATION has now been declared compulsory in Constantinople (*Arch. Or. de Med.*). Parents who neglect to have their children vaccinated are liable to a fine of 150 piastres, for each unvaccinated child.

MR. M.S.—We thank you for your suggestion, but at this season the contingency is unlikely to present itself.

IRATUS.—There can be no objection to your bringing your views to the notice of the Medical Board, though we cannot promise that they will be received in the spirit in which they are made. If you could induce an eminent specialist to endorse your contention it might carry more weight.

Meetings of the Societies and Lectures.

WEDNESDAY, MAY 16TH.

ROYAL MICROSCOPICAL SOCIETY (20 Hanover Square, W.)—7.30 p.m. Exhibition of Pond Life.

THURSDAY, MAY 17TH.

HARVEIAN SOCIETY OF LONDON (Stafford Rooms, Titchborne Street, Edgware Road, W.)—8.30 p.m. Paper:—Dr. D. Buxton: Incidents in Surgical Anaesthesia.

FRIDAY, MAY 18TH.

EPIDEMIOLOGICAL SOCIETY OF LONDON (11, Chandos Street, Cavendish Square, W.)—8.30 p.m. Ordinary Meeting.

ROYAL ACADEMY OF MEDICINE OF IRELAND.—Medical Section.—Papers:—Dr. H. C. Drury: A Case of Cerebro-spinal Meningitis. Dr. A. B. Parsons: Cerebro-spinal Meningitis. The remainder of the evening will be devoted to the discussion of Cerebro-spinal Meningitis.

Appointments.

COLLINS, E. TREACHER, F.R.C.S. Eng., Surgeon to the Royal London Ophthalmic Hospital, City Road.

CROSSFIELD, A. K. L.R.C.P., L.R.C.S. Edin., Medical Officer for Dartmouth Sanitary District, Totnes Union.

FISHER, J. H., F.R.C.S. Eng., Assistant Surgeon to the Royal London Ophthalmic Hospital, City Road.

FLEMING, FERG., M.D. Lond., Assistant Surgeon to the Royal London Ophthalmic Hospital, City Road.

JACKSON, J. J., L.R.C.P. Edin., L.R.C.S. Irel., has been re-appointed Medical Officer of Health by the Wakefield Urban District Council.

JACOBSON, G. O., L.R.C.P. Lond., M.R.C.S., Medical Officer for the Fourth Sanitary District of the Chipping Norton Union.

JAMES, JOHN, L.R.C.P. Lond., M.R.C.S., Certifying Surgeon under the Factory Acts for the Talybont District.

KENDALL, W. R., L.R.C.P. Edin., M.R.C.S., Medical Officer for the Kingswear Sanitary District, Totnes Union.

KIRKBY, W., L.R.C.P., L.R.C.S. Ed., L.F.P.S. Glasg., Medical Officer of Health by the Maesteg Urban District Council.

LAWSON, ARNOLD, F.R.C.S. Eng., Assistant Surgeon to the Royal London Ophthalmic Hospital, City Road.

NORMAN, A. S., L.R.C.P. Lond., M.R.C.S., Medical Officer for the Second Sanitary District and Workhouse of the Havant Union.

OPPE, EDWARD AUGUSTUS, M.R. Durh., M.R.C.S. honorary Medical Officer to the Wellington (Somerset) Cottage Hospital.

O'SULLIVAN, C. N., was re-elected Senior House Surgeon, and JAMES DUNNE, Junior House Surgeon, to the Jarvis Street Hospital.

BRIMMER, J. F., M.B., Ch.B. Vict., Resident Assistant Medical Officer for the Workhouse of the Birkenhead Union.
ROBERTS, KILHAM, L.R.C.P. Lond., M.R.C.S., Medical Officer of Health for the combined Asaph and Woburn Rural Districts.
SPICER, W. T. HOLMES, F.R.C.S. Eng., Surgeon to the Royal London Ophthalmic Hospital, City Road.
WHILLIS, SAMUEL SMOR, M.D., B.S. Durh., Hon. Surgeon to the Fleming Memorial Hospital for Sick Children, Newcastle.

Vacancies.

Bristol Royal Hospital for Sick Women and Children.—Hon. Surgeon. Salary £120 per annum, with rooms and attendance but without board.

City of Glasgow Fever Hospital.—Physician Superintendent at the Belvedere Hospital. Salary £400 per annum, with house accommodation, board, and attendance. Applications to Mr. Lindsay, City Chambers, Glasgow.

County Asylum, Rainhill, near Liverpool.—Assistant Medical Officer as Locum Tenens for about four months during the summer. Salary £3 3s. per week, with furnished apartments and board.

County Borough of Halifax.—Medical Officer of Health for the Borough. Salary £500 per annum. Drugs, medicines, and surgical appliances provided by the Corporation. Applications to the Town Clerk, Town Hall, Halifax.

Cork Street Fever Hospital.—Assistant Registrar and Resident Medical Officer. Salary £80 per annum, with furnished apartments, board and residence. Applications to be addressed to the Chairman. (See advt.)

Craiglockhart Poorhouse and Hospital, Edinburgh.—Resident Medical Officer. Salary £100 per annum, with board and apartments. Applications to the Clerk of the Parish Council, Council Chambers, Castle-terrace, Edinburgh.

Cumberland and Westmorland Asylum, Garlands, Carlisle.—Junior Assistant Medical Officer, unmarried. Salary £130 a year, rising to £150, with board, residence, &c.

Durham County Asylum, Winterton, Ferryhill.—Second Assistant Medical Officer. Salary £170 per annum, rising £10 annually to £220, with rooms, board, laundry, and attendance.

Essex and Colchester Hospital, Colchester.—Resident House Surgeon. Salary £100 per annum, with board and washing.

Gateshead Union.—Assistant Resident Medical Officer for the Workhouse. Salary £150 per annum, with apartments, rations and washing. Applications to the Clerk of Union, Gateshead.

Great Northern Central Hospital, Holloway Road, London.—House Physician for six months. Salary at the rate of £80 per annum, with board, lodging, and washing in the hospital. Also Junior House Physician for six months. Salary at the rate of £39 per annum, with board, lodging, and washing in the hospital. (See advt.)

Manchester Children's Hospital, Pendlebury.—Medical Officer for the Dispensary. Salary £180 per annum. Applications to the Secretary, Children's Dispensary, Gartside Street, Manchester.
Ripon Dispensary and Cottage Hospital Ripon.—Resident House Surgeon and Dispenser, unmarried. Salary £100 a year, with board and lodging.

Royal Southern Hospital, Liverpool.—Honorary Physician on the staff. Also a Junior House Surgeon. Salary, including board, &c. £84 per annum, with a bonus of £5 5s. quarterly.

Royal United Hospital, Bath.—House Surgeon on June 1st for four months. Salary at the rate of £100 per annum, with board, lodging, and washing.

Sussex County Hospital, Brighton.—Resident Pathologist, unmarried. Commencing salary £40 per annum, with board, residence in the hospital, and washing. Also House Physician, unmarried. Commencing salary £50 per annum, with board, residence in the hospital, and washing.

Three Counties Asylum, near Hitchin.—Second Assistant Medical Officer (male), unmarried. Salary commencing at £150 per annum, with board, apartments, washing, and attendance.

Warneford Hospital, Leamington.—House Surgeon. Salary £100 per annum, with board, lodging, and washing.

York Lunatic Asylum, Bootham, York.—Assistant Resident Medical Officer. Salary £130 a year, with board, washing, and attendance.

Births.

FARTHING.—On May 9th, at 17, Highfield Road, Dartford, the wife of T. Farthing, M.B., of a daughter.

ROSS.—On May 7th, at Kiloran, Hilsea-terrace, Portsmouth, the wife of Richard Adolphus Ross, Surgeon Royal Navy, of a son.

Marriages.

JONES—RUSSELL.—On May 8th, at St. Peter's, Chalfont, Dr. J. Llewelyn Jones, of Melton Mowbray, son of David Jones, of Aberdare, to Helena Margaret, second daughter of the late Canon and Lady Mary Russell.

Deaths.

DRUMMOND.—On May 5th, at Stoneycroft, Wakeham, Portland, Duncan Drummond, M.B., C.M., aged 38 years.

FLEMING.—On May 7th, at Manor-place, Edinburgh, James Boyd Fleming, M.D., Deputy Inspector-General of Hospitals.

ILLINGWORTH.—On May 3rd, at Boshof, South Africa, Thos. Wm. Illingworth, M.D., aged 36.

THISTLE.—On May 7th, suddenly, of heart disease, at 12, Inverman-terrace, W., William G. Thistle, B.A. Oxon., M.R.C.S.E., L.R.C.P., aged 43 years.

TYACK.—On May 7th, at Westgate, Chichester, Nicolas Tyack, M.D. Edin., F.R.C.P. Lond., J.P. for Sussex and Chichester, aged 87.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

Vol. CXX.

WEDNESDAY, MAY 23, 1900.

No. 21.

Original Communications.

AN UNCOMMON CASE OF LATE RICKETS. (a)

By E. MUIRHEAD LITTLE, F.R.C.S.,
Surgeon to the National Orthopædic Hospital.

MINNIE R., æt. 17, was sent to me in October, 1899, by Dr. Frank Cowan, of Strood, Kent.

No history was to be got from friends, but her own account of herself is clear and intelligible. She says that she was quite well and able to run about until she was five years of age when it was noticed that her knees were giving way. She then wore splints and afterwards instruments. She could walk about with these appliances until she was seven years old, when she was obliged to have crutches. She has not been able to go without them since. When eight years old she fell and broke the right thigh above the knee and the left one in a similar position a year later. She comes from a hard water district. She has not menstruated. The family history is negative.

The following are notes of her condition in October last:—

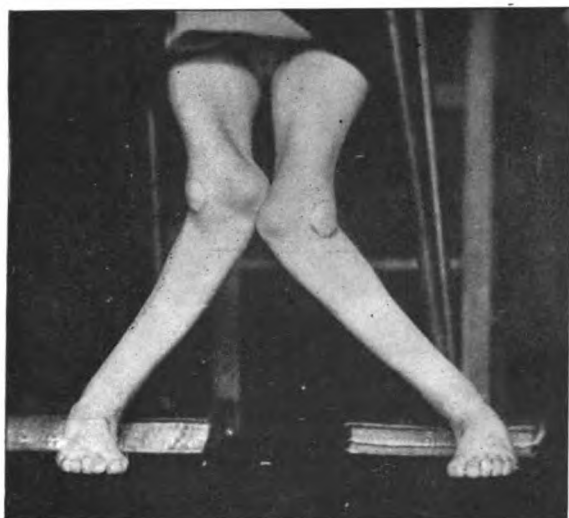


Fig. 1.—Photograph of Knees (front view).

Patient is a pale, delicate-looking girl. Her body and limbs are well nourished. Her length recumbent is 44 inches. Her forehead is rather prominent. The skull is slightly flattened at the vertex. The lower part of the face is small in comparison and the features pinched, the upper front teeth project over the lower lip. There are several carious teeth. (It is therefore not possible to absolutely exclude infantile rickets.) The

(a) Shown at the meeting of the Medical Society of London, April 9th, 1900.

thorax is fairly well formed, but slightly constricted about the fifth to seventh ribs laterally, and there is beading at the ends of these ribs. There is nothing like pigeon-breast, but, on the contrary, the front of the chest is rather flat.

The breasts are very ill-developed. The clavicles are not unduly curved, but their inner ends are somewhat prominent.

The abdomen is rather large, but the liver and the spleen are not enlarged.

The spine is not deformed, nor is the pelvis. The distance between the anterior superior spinous processes of the ilia is 8½ ins. There are only a few scattered hairs about the pudendum and mons Veneris. There is some enlargement of the upper ends of the humeri, and exaggeration of the normal curves of the bones of the arms and forearms. The lower extremities of the bones of the latter are much enlarged, but not tender. The lower limbs are much deformed, as shown in the accompanying photographs (Figs. 1 and 2), but the deformity is mostly confined to the femora. These are much bent in a wide curve, having its convexity looking forwards and outwards. This curve is sharpest in the lowest fourth of each bone, and in all accounts for an altera-



Fig. 2.—Photograph of Knees (side view).

tion of the direction of the lower articular surface amounting to 75°.

The tips of the great trochanters are slightly below Nélaton's line. The patellæ lie on the antero-external aspects of the joints. They were outlined in ink before the photographs were taken, and their position is thus obvious in the prints.

The shafts of the tibiæ and fibulæ are not obviously deformed, but their lower ends are, perhaps, larger than normal.

There is extreme knock-knee. When recumbent with the internal condyles touching each other, the angle between tibiae is one of 80° , and the internal malleoli are 14 inches apart.

Flexion of the knees is free, and lateral movement is possible to an abnormal extent. Full extension is apparently impossible, but the appearance is due more to the great curve of the femur than to the condition of the joint itself.

The limit of extension is shown in the photograph (side view) Fig. 2. The feet are slightly rotated outwards (varus). When the patient uses her crutches a kind of scissor-legged position is assumed. She progresses by abducting one thigh, flexing the knee and passing it round to the front of the other one.

On October 18th, 1899, I performed MacEwen's osteotomy on the right femur. To my surprise the second blow of the mallet drove the osteotome right through the bone, which seemed to be so soft that it could have been divided with the chisel without the aid of a mallet. The deformity was corrected laterally, but very little improvement in an antero-posterior plane was possible.

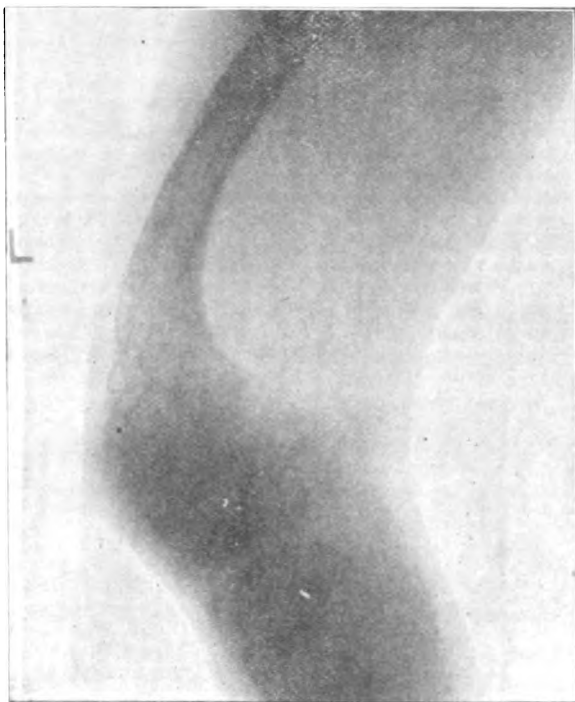


Fig. 3.—Skiagraph of Femur (side view).

On January 5th, 1900, as there was still some doubt as to the nature of the union of the fracture, a skiagraph was, after some difficulty, obtained. The bones threw faint shadows, no doubt owing to deficiency of mineral matter, and the question of union remained doubtful. Osteotomy on the left knee was therefore postponed, but the ilio-tibial band was divided near its lower end and splints were applied as it seemed probable that such porous bones would easily yield to continued pressure. On April 2nd, 1900, the skiagrams reproduced in Figs. 3 and 4 were taken. Fig. 3 shows, I think, that there is good union of the divided right femur. The skiagram of the wrists is referred to further on.

At the present time the genu valgum is corrected on the right side and the patella is in its proper position on the front of the knee. There is considerable improvement of the left knee, but the patella is still displaced outwards. Osteotomy will probably be necessary here also.

The patient's length recumbent is now 47 inches. The calculated increase in height from the correction of the genu valgum is 2.9 inches. Thus there has been little or no growth during the last six months. In other respects her condition is little changed since I first saw her.

Her weight without clothes is $49\frac{1}{2}$ lbs., yet the patient is by no means emaciated. The urine passed during 24 hours was collected on April 1st. It amounted to fifteen ounces, and was analysed for me by the Clinical Research Association. Briefly summarised, the report states that the percentage of all the constituents, except calcium, was normal, and that there were no abnormal substances present. The absolute quantity of its constituents was like the quantity of urine, about *one-third* of the normal average, while the calcium (estimated as Ca O) was present in about half the average percentage, the absolute amount present being about *one-sixth* of the normal average.

As the patient weighs less than fifty pounds,



Fig. 4.—Skiagraph of Wrist of Minnie R.—

probably the excretion of urine should be as it is, *one-third* that of an average healthy adult weighing say 150 lbs.

This case is, I think, uncommon enough to merit record; few similar ones have been recorded. It resembles in its main features that described by Dr. Drewitt in the Pathological Society's "Transactions" for 1880, Vol. XXXII., and those by Mr. Clutton, in Vol. XIV. of the St. Thomas's "Hospital Reports," 1884, and I have, therefore, felt justified in applying the term "Late Rickets" to it, especially as the skiagram shows in the ends of the bones of the forearms a condition like that which is found in infantile rickets, and is shown in Fig. 5.

If this skiagram (Fig. 4) be compared with the excellent ones of the normal wrists at various ages, which are published by Mr. Poland in his Skiagraphic

Atlas, it will be seen that it forms a very marked contrast. Instead of the narrow, clearly defined zone separating the shadows of the diaphysis and epiphysis, a wide, ill-defined, blurred space intervenes. In this space irregular deposits of lime salts have produced dark streaks in the print. At the same time there appears to be some tendency to "cupping" of the bony ends of the diaphyses.

This "cupping" is well shown in the wrists of the typically rickety child of 2½ years, from which the skiagram (Fig. 5) was taken. The concave ends of the diaphyses are in marked contrast with the normally convex ones of a healthy child of 2 years old, which are shown in Fig. 6.

Although the patient herself states that she was well until about five years of age, it is still possible that the disease began in early infancy, and that this is a case of continued rickets, rather than of rickets be-

rather support this view, as the later ones show the bones to be rather denser than do the earlier ones.

In sexual development my patient is very backward more so than Mr. Pitts's (recorded by Mr. Clutton), and in marked contrast to the precocious development of Mr. Clutton's own patient. Dr. Drewitt's was a male.



Fig. 5.—Skiagram of Wrist of a Typically Rickety Child of 2½ years.

ginning in the fifth or sixth year. I do not think that this is probable, but were it so, the case would still be remarkable as showing the continuance of the disease for 15 or 16 years, for the softness of the bones as found on operation, their perviousness to X-rays, and the appearance of the epiphyses in the skiagraph are evidence that the disease still persists. It appears, however, to affect the skeleton almost exclusively, as there is no evidence of visceral disorder.

The deficiency of calcum in the urine is striking. The patient for the last six months has had full mixed diet, and has been drinking the hard water supplied by a London water company. She should therefore ingest enough lime salts to produce the average amount of Ca O in her urine. I would suggest that the deficiency is to be possibly explained by the commencing subsidence of the disease, and by an increased amount of lime being therefore needed for the recalcification of the bones. The skiagrams



Fig. 6.—Skiagram of Wrist of a Healthy Child of 2 yrs.

Cases of bending of the long bones in adolescents, and the production of such deformities as knock-knee are not very uncommon, but marked enlargement of the epiphyses does not occur in such, and it is not certain that they are due to rickets. The very marked resemblance to infantile rickets of this patient and those of Dr. Drewitt and Mr. Clutton, and the post-mortem appearances in Dr. Drewitt's patient justify the name of late rickets.

THE TEACHING OF INSANITY.

By SIR JOHN BATTY TUKE, M.P.,

President of the Medico-Chirurgical Society of Edinburgh;
Morison Lecturer on Insanity, &c.

THE lecturer directed the attention of students mainly to the proper principles on which that study should be conducted. He deprecated strongly the use of the term "mental disease" as misleading, and adduced a series of arguments to show that mental alienation was merely a symptom of many various diseases of the brain. After reviewing the history of the development of anatomical, physiological and pathological facts during the last thirty-five years, and their bearing on the study of the insanities, he observed that one of the main difficulties of teaching the subject was the almost entire absence of means of illustrating clinically the various conditions in their earliest stages—the stages during which they were more amenable to treatment, and came under the observation of the general practitioner of medicine. Proceeding, he said: In one way an asylum is the worst place to teach the

general practitioner, inasmuch as we can only show him cases more or less confirmed. You will have to deal with incipient cases, and these we cannot show you. If we are to look for a decrease in the amount of insanity we must depend to a great extent on the general practitioner, who deals with it during the stage when removal to an asylum is not permissible; and if he is not thoroughly instructed how to deal with such cases, a continual increase of lunatics must be anticipated. This is a matter of considerable public importance, and I propose to conclude with a few remarks bearing upon it, taking for my text the fact that year by year the number of lunatics is increasing. I do not say there is an increase of lunacy in the sense that a larger number of cases have occurred in relation to the population, say, between 1890 and 1900 than between 1870 and 1880. But whereas in 1870 there were 6,000 pauper lunatics in Scotland, in 1898 there were 12,000. The incubus is getting heavier year by year, new and costly asylums have to be built, and old ones increased in size, and the ratepayer groans. I do not appeal to the citizen as a ratepayer, but as a humanitarian, when I ask him to consider whether there are no means of preventing the accumulation of cases of these most distressing diseases. What is the main cause of this accumulation? The answer is simple. Of every 100 patients admitted to asylums from 50 to 60 are discharged recovered or improved, and from 10 to 15 die leaving a very appreciable residuum of cases which have become chronic. You must not blame asylum physicians for this result. The reason why the percentage of recoveries in asylums is not much greater is that cases are not submitted to treatment at a sufficiently early period. I have told you that if the physician has a case of insanity placed under his care at its commencement, or shortly after, it is very amenable to treatment. Undoubtedly there are certain forms which are not so; they are hopeless, or almost hopeless, from the beginning; but, allowing for such, it may be stated that about 75 per cent. of all cases should recover if placed under fitting circumstances at an early stage. Statistics show that the increase of chronic lunatics occurs among the poorer classes of society and not among the rich. This is due to the latter being able to place members of their class showing symptoms of incipient insanity under systematic treatment at home, whilst the former are compelled to allow matters to drift till their cases become more or less confirmed. Treatment at home is necessarily costly as it involves nursing, possibly change of residence, and continuous medical attendance. This is out of the power of the poor to obtain. All general hospitals shut their doors against persons suspected of insanity (unless it be the acute insanity produced by drink) on the ground that the asylum is the proper place for their treatment. The asylums, however, cannot receive cases until the symptoms are so far advanced as to warrant their being certified as absolutely insane—that is to say, when they are in such an advanced stage of disease as lessens the probability of recovery or renders the case hopeless. The extreme delicacy of the brain structure demands early and assiduous treatment. Many a practitioner has had to watch a case passing through the curable stage—the stage in which the mental condition does not amount to absolute insanity—but the symptoms of which are such as to indicate that positive insanity must supervene if not dealt with. He is not in a position to grant a certificate in accordance with the requirements of the law. He is helpless because he has not the means at his disposal for proper treatment. Now, I am convinced that were it thoroughly ingrained in the mind of the public that insanity is a symptom of bodily disease, measures would be

adopted by which it could be treated in time. In the first place, suitable wards would be provided in all general hospitals and infirmaries where, let us call them, "nervous patients" could be accommodated for limited periods, and treated on the general principles of medicine. I have not the slightest hesitation in saying that a very large proportion of such cases would be cured in limited periods of time, and those who did not recover could, after a reasonable period, be relegated to asylums. Without some intermediate hospital for the poorer classes, there must inevitably be a constant and gradual accumulation of chronic cases. If we consult asylum statistics, we find that there is a distinct ratio between the number of recoveries and the length of time patients have been insane. The shorter the period the greater the number of cures—something like one month 50 per cent., three months 30 per cent., six months 15 per cent. I do not say these figures are strictly accurate, but they illustrate roughly the ratio. If the general hospital cannot provide sufficient means for treatment, the public must, if only in self-defence, make provision. This is not the time to suggest an elaborate scheme, but let me say wards in connection with poor-houses would be better than nothing. But I believe better than this will come. Parochial authorities will see that it is their best policy to give their medical officers means of treating such cases in the same manner as those occurring among the rich, and will provide either cottage hospitals or country quarters for the afflicted. This is not a socialistic suggestion, it is an economic one, and it is offered to a public which is spending money at the wrong end. Is it reasonable to be building year after year palatial residences at a cost of from £350 to £450 per bed for the chronic insane, who cannot appreciate and who do not need such magnificence, and to leave out in the cold early incipient cases, who require and could appreciate a certain degree of luxury? I will give place to no man as regards sympathy with the insane, but a long experience convinces me that the humanitarian sentiment of the public is expending itself in a wrong direction. Let us be as lavish as is right in treating in its early stages a disease which afflicts three in every 1,000 of the community, and when we can do real good; and to find the money for the purpose let us exercise economies effected by saving what we waste on uncalled for and utterly unjustifiable extravagances.

PORRO'S OPERATION FOR RUPTURED UTERUS COMPLICATED BY MYOMA AND FIVE- AND-A-HALF MONTHS' PREGNANCY. (a)

By DR. COLE-BAKER.

I WAS sent for at 2 p.m. on Sunday, August 6th, 1899, to see the patient in consultation with Dr. Furlong. Her age was 38. She was married two years. She had an abortion (about third month) in February, 1898. General health always good. Menstruation normal, but suffered more or less from constipation from time to time. She was pregnant (for the second time) from five-and-a-half to six months. She had taken ill with vomiting and "cramps" (P) four days previously. Her pulse and temperature were normal. Dr. Furlong had sent for me because on making a per vaginam examination of the patient he had failed to discover a cervix uteri or os externum.

(a) Read before the Section of Obstetrics, Royal Academy of Medicine in Ireland, April 20th, 1900.

On palpating the patient, I found the "fundus" (?) reaching to the umbilicus, and labour pains existing; and per vaginam I found the true pelvis tightly filled with a tense elastic tumour. At first no cervix or external os could be felt, but, on more careful examination, the latter (the posterior lip only of which could be reached with much difficulty) was discovered about two inches above the upper border of the symphysis pubis. I came to the conclusion that I had to deal with a case of retroverted and "incarcerated" gravid uterus (posterior acculation), with labour pains present, and that prompt action was necessary or rupture of the uterus must ensue sooner or later.

Chloroform was administered by Dr. Furlong; and with the patient in the cross-bed position an attempt was made to replace the uterus, but it was unsuccessful, owing to imperfect anaesthesia, a low and rickety bed, and want of proper assistance. I therefore advised the patient to come into the Coombe Lying-in Hospital. She did so at once, and having been *profoundly* anaesthetised by Dr. Neill (Assistant Master), was placed on a high, rigid operation table, Dr. Winifred Dickson (ex-Assistant) and Dr. R. H. Fleming (late Assistant, Rotunda) were invited to examine the patient. They did so, and confirmed the diagnosis, but I discovered later on that, owing to unintentional manipulation by Dr. Fleming and the perfect relaxation of all the tissues now existing, the uterus had slipped up out of the pelvis into its normal position. The patulous external os could now be quite easily felt, and was dilated to about the size of a florin. A No. 8 Smith-Hodge pessary was introduced to prevent the recurrence of retroversion. Palpation now gave the impression that the tumour was a uterus bicornis, the right cornu being somewhat the larger and harder of the two. I concluded that the sulcus between the apparent cornua was due to the pressure of the promontory of the sacrum upon the uterine wall during its incarceration in the pelvis, and that the so-called right cornu had been the lower of the two in the pelvis—the presenting tense elastic tumour felt at my first examination. All uterine contractions had now ceased. The patient was put to bed, given tr. opii, ℥xx., and slept well.

Bed card notes for August 7th to 12th, both inclusive:—

August 7th.—Pulse and temperature normal, a.m. Some vomiting. Given bismuth subnit. c. soda bicarb. in powders. An enema acted well.

8th.—Temperature, a.m., 99°6'; pulse, 100. Very restless night till given tr. opii, ℥xx., when she slept some hours. Complaints of pain if she lies on left side.

9th.—Bad night. Pain and extreme tenderness of abdomen, especially over so-called right cornu. Pessary removed. Vaginal douche (creolin 1 per cent.) given. Hot belladonna stupes applied, and, later, morphia sulph., gr. ½, given. Highest temperature, 99°4' at 8 p.m.; pulse normal.

10th.—On this date I came to the conclusion that the so-called right cornu was a myoma which had got damaged in the pelvis or during its replacement, and that the extreme tenderness (the patient winced if anyone looked at her abdomen) was due to a localised peritonitis. Dr. W. J. Smyly (late Master of the Rotunda Hospital), who saw the case on this date, concurred in this opinion. At this time (about 3 p.m.) her temperature was 103°4', her pulse 108. The pain was much increased. She got phenacetin, grs. v., and morph. sulph., gr. ½ (hypodermically).

11th.—A fair night, but a.m. temperature 103°6', with pulse 104. Some vomiting, and the tenderness over tumour (? myoma) simply exquisite. I believed that sloughing of the tumour was going on, and that laparotomy was indicated; but Dr. Kidd (the Master of the Hospital) was of opinion that a localised peri-

tonitis, brought about as has been already suggested, would account for the patient's condition, and that, so far, operative interference was unjustifiable.

About mid-day on this date Dr. Kidd made a vaginal examination, and there were then absolutely no signs of impending labour (the external os being tightly closed); nevertheless, about 6.30 p.m. that same evening, without any warning or labour pains, the patient was delivered of a male foetus about five-and-a-half months, with the membranes intact. A uterine douche (creolin 1 per cent.) was given. There was no hæmorrhage. At 8.30 p.m. temperature 103°2', pulse 116. Given phenacetin, grs. v., in brandy, ʒss. At 11.30 p.m. temperature 104°4'. Brandy as before, and phenacetin, grs. x. Body sponged, and finally wet pack (cold).

12th.—Was given brandy, ʒss, every hour till 3 a.m., when temperature had fallen to 99°; but at 5.30 a.m. it was again up to 100°6'. Temperature varied between 104° and 99° during day, and pulse between 112 and 134. Sponged several times. Brandy, ʒss every hour. Phenacetin, grs. v, twice, and morphia, gr. ½, once. Slept a good deal, and took nourishment fairly during the day. Phenacetin, grs. x, at midnight.

On August 13th (day of operation) I saw the patient at 10 a.m. She had been rambling during the night, and had had three slight rigors. She looked thoroughly septic. Temperature at 9 a.m. 100°8', pulse 104. Was drowsy and dull, but when roused said she "felt splendid and had no pain at all." There was scarcely any tenderness, even when pressure was exerted, over abdomen—in fact she was in the condition of euphoria, the most dangerous of all conditions in such cases.

Having reported to Dr. Kidd, he and I saw the patient together, and all puerperal elements having been eliminated, decided to open the abdomen. By this time (4 p.m.) her temperature was 105°, pulse practically countless, delirium had set in. She was, in fact, moribund. With Dr. Kidd's kind permission and assistance I performed an abdominal hysterectomy by Porro's extra-peritoneal method. The appendages were removed with the uterus. By 8 p.m. (i.e., in 3½ hours) the temperature had fallen to 97°4', and pulse to 99. Convalescence was complete in 26 days; the sutures were removed on ninth day, and stump separated on twelfth day.

The patient was seen by me subsequently on Jan. 4th, 1900. The cicatrix was perfect, and much diminished in length and breadth. No traces of the stump having been brought into the lower angle of wound remained. Patient was fat and well, and said she never felt better in her life. On resuming marital relations she at first felt considerable pain, but it was then practically nil. There is no vesical trouble whatever—in fact, micturition is not nearly as frequent as before the operation.

The tumour after removal revealed a condition of things that I certainly had not suspected, nor do I think anyone who had seen the case had either. The diagnosis of a myoma was correct, no doubt; but it was found that this myoma (which was about the size of a foetal head at term) had caused a rupture of the uterus at the fundus between the two orifices of the Fallopian tubes, and that the myoma was sitting in the uterine wall much as an egg does in an egg-cup. There had been no hæmorrhage whatever into the abdominal cavity, and all one noticed was some congestion of the blood-vessels on the surface of the portion of the myoma that protruded through the rent in the uterus.

I think the specimen shown will interest some of the members of the Section, and I should be glad of enlightenment upon the following points, which certainly puzzled me:—

a. When did the uterus rupture?

b. Why did labour supervene so painlessly, rapidly, and so long (six days) after the replacement of the uterus?

c. What caused the sudden rise of temperature on August 10th, and the still higher rises on the 12th and 13th.

In seeking an explanation of the last question, at the suggestion of Dr. Smyly, I made a vertical incision through the myoma and cavity of uterus, but there was no trace whatever of sloughing in the tumour, and the interior of the uterus was quite healthy. A sound passed through from the os internum slipped easily between the tumour and the jagged edge of the uterus at the line of rupture, demonstrating that the latter was complete (*i.e.*, involved all of the coats of the uterus).

It has been objected that the operation I performed was not Porro's, on the ground that the patient was not "gravid" at the time. However, it was performed by Porro's method, and the uterus was a puerperal one at any rate. I have been asked why I chose the extra-peritoneal method, but I did not choose it, but adopted it as the most rapid method, as in this case time was everything; as when the patient was put upon the table I scarcely expected her to live to be taken off it again. It was, perhaps, early for me to venture an opinion as to the merits of the various methods of performing partial or complete hysterectomy; nevertheless, where the vaginal and supra-vaginal portions of the cervix are healthy, and there is no cause for extra haste (as there was in this case), I give it as my firm conviction that Porro's intra-peritoneal method is the ideal one.

I believe, too, that in the operation I performed, the tendency was to be too greedy, and drag the cervix up into the abdominal incision far more than was at all necessary, thereby bringing about the painful dragging feel that is so frequent after these operations, in addition to the bladder trouble (difficulty of retention) that so often arises.

In regard to Doyen's method for hysterectomy as I have seen it performed (and that was in strict accord with the description given in Doyen's own book), I cannot call it a strictly aseptic method. I believe that its greatest merit lies in the fact that large blood vessels are avoided—a point alluded to by Dr. Smyly when bringing the first case performed by this method in Ireland before the Academy in May, 1899.

THE METABOLISM OF CHLORINE IN THE ANIMAL ECONOMY.

By DR. SIEGFRIED GROSZ.

IN PROF. MRACEK CLINIC FOR SKIN DISEASES, VIENNA.

(Specially reported for THE MEDICAL PRESS AND CIRCULAR.)

SINCE the days when Liebig, in 1851, declared sodium chloride to be a constant constituent of the body, being always present in the ash when analysed, we have gradually grown out of the habit of regarding it merely as a condiment or dietetic luxury, and have learned to recognise this salt as an essential constituent. To show the importance of this constituent in the animal economy an experiment which Wundt carried out on himself may be introduced here as confirming this view. For five days he entirely excluded sodium chloride from his diet while taking an ample quantity of the other necessary constituents of the body, his diet consisting of $\frac{1}{2}$ kilo. of meat (0.55lb), 500 grammes of vegetables (1.1lb), and 600 grammes of bread, all free from sodium chloride. An analysis of the urine gave the following results:—

During first day	7.21 grms.	of Na Cl	were eliminated.
" second day	3.62	"	"
" third day	2.44	"	"
" fourth day	1.36	"	"
" fifth day	1.09	"	"

It should be noted here that albumen appeared in the urine on the third day, increasing in quantity on the fourth and fifth days.

The same condition is true of animals. Forster fed pigeons on a chlorine-free diet, and they died in 13, 25, and 29 days respectively. He also fed dogs on a similar chlorine-free diet, and they became so enfeebled on the 26th to the 36th day that death appeared inevitable if further deprived of this necessary constituent. This shortness of the period is somewhat surprising, when we remember that a dog will live 60 days without food at all. To explain this apparent paradox Bunge tells us that when albumen is oxidised sulphuric acid is formed, which, if not neutralised by the sodium chloride, will act as a toxic agent in the system, a view which is borne out by the results of these experiments.

Lunin's experiments on mice tend to confirm this hypothesis. He fed five mice on almost chlorine-free food, consisting of cheese, raw sugar, and distilled water. In from 11 to 21 days they all died. He next arranged a dietary with an equivalent of sodium that would combine with all the sulphur in the cheese, so that no free sulphuric acid would be present; the five mice he kept on this diet only lived from 23 to 36 days. Forster attempted to prove that the balance of nitrogen was affected in the animal organism by a deficiency of any of the salts, but that a reduction of chlorides would tell most on the vegetable eater rather than the meat eater. To test this opinion Bunge undertook the feeding of both classes of animals with similar quantities of potassium and sodium chlorides, and found them much about the same in regard to these substances, but, strange to say, the herbivora required from twice to four times the amount of potassium. It is probably this circumstance that lead to the assumption of a greater amount of soda being required than was actually given, which is owing to the chemical change occurring in the organism. In potassium salts, the electro-negative constituent whereof is other than chlorine, an exchange will take place forming a new compound, for example, when phosphate of potassium is administered with chloride of sodium the chlorine will combine with the potassium and the phosphorus with the soda; when this takes place in the plasma of the blood both salts are rapidly eliminated by the kidneys and leave the blood in the original normal condition. It follows therefore that a herbivorous animal taking a large quantity of potassium salts will organically require a larger quantity of sodium chlorides to maintain the normal balance of chlorides and sodium salts in the organism. To demonstrate this *a priori* deduction, Bunge experimented on his own person by taking phosphate and citrate of potassium, which increased the elimination of chlorine to six grammes of sodium chloride, or about 92.5 grains above the average which would soon exhaust the body supply. It is also found that hunger will reduce the chlorides in the urine to zero, though the tissues of the body continue to yield the normal amount. Landsteiner fed 30 young guinea pigs for three-and-a-half months, 15 of them on milk alone, and 15 on meadow hay, so that each group of animals ingested very different quantities of potassium and soda. The chemical examination of the blood at the end of this time was the same in soda and potassium in both groups of animals.

Forster drew a distinction between the circulating salts of the body and those combined with the non-combustible substances of the body, in other words

between those of the blood and the tissues. Those in the blood are loosely combined, and are easily decomposed and oxidised in the presence of other combustible substances, and are rapidly eliminated by the kidneys, in which, when passing, they part with the albumen with which they may have been temporarily combined, although in diabetes this rule does not obtain. Under this condition the constant burning up of the albumen will be continually setting free an excess of salts for elimination. This will again reduce the process to albuminoid consumption and production; if the food supplied and absorbed from the alimentary canal be transmitted to the blood with a deficiency of salts it will naturally combine with the excess of salts in the blood, and finally become deposited in the tissue of the body, but when this albumen is again decomposed and eliminated the salts are again set free. According to Voit's experiments this opinion is confirmed. He affirms that the salts all come away *via* the kidneys, unless there is a marked sweating. In feeding dogs he added a large quantity of common salt to the ingesta, which rapidly increased the amount of salt in the urine. If, however, the blood had been deprived of this saline material the quantity eliminated was not so great at first, but gradually rose to the maximum; again, if the converse method were employed with a non-saline material and an excess of salts in the blood the elimination of salts would be normal at first, but afterwards gradually decline to the minimum.

Notwithstanding the long-established theory that had its votaries, and still has many ardent exponents of increased metamorphoses in the presence of sodium salts there remains a group of experimenters who cannot convince themselves of this transformation. Boussingault's experiments on the reindeer were unaffected by the absence or presence of common salt, which did not affect the flesh, the fat, or the milk. Barral found in feeding sheep with salt food that they fattened, while those fed with the same food without salt remained of the same weight. Bishoff and Kaupp found the urine of both dogs and men increased by administering salt in the food. Voit also found the urine constituents increased when the body weight was stationary. Weiske had a similar experience in feeding sheep with salt food. This, however, must be accepted with considerable reserve.

According to Salkowski, this excretion of an excess of urea is not continuous, but simply washes out the renal organs. In his experiments, which were continued 49 days, the total excess of urea passed was only 105 grammes, or 1,620 grains, which means a very small amount of albuminoid transformation; giving an average of 3 grammes per diem of excess.

Chloroform is another agent which acts as an eliminator of chlorides. Mylius found in his experiments on dogs that after administering 10 grammes of chloroform the elimination of chlorine was increased from 0.138 to 1.482. Kast found a similar condition after a protracted administration of chloroform. Levianski obtained an opposite result by administering the trichlor-butyrates of soda. Kast also tells us that by subcutaneously injecting 3 grammes of pyrogallol, and 0.5 gramme of toluylendiamin, the chlorides are increased. Among the physiological experiments the administration of carbon monoxide is interesting. If given to an animal normally saturated with chlorides, the urine gradually becomes chloride-free on the third or fourth day; if, on the other hand, the CO be administered to an animal which has been starved of chlorides, these salts rapidly appear in the urine.

From these experiments Kast concludes that there are two primary factors operating in the elimination of chlorides, viz., the amount of albumen metabolism, and the amount of destruction of the red-blood

corpuscles which, though it exerts no influence over the transformation of tissue, increases the elimination of chlorine. The effect of destruction of the corpuscles in increasing the chlorides is not easily explained, as the opposite effect would be expected from the injury inflicted on the process of metabolism. Bleeding, in opposition to the preceding, reduces the chlorine in the urine. Kast removed from dogs 200 cc. of blood after which the chlorine was reduced from 0.46 to 0.057 gramme. In two females who had aborted, one had 2.6 and 1.9 of chlorine in the urine during the two following days, while the other had 1.9 and 2.0 grammes. In both cases the food was not altered in any particular. This may have been due to the depletion that would reduce the Na Cl in the plasma. Chlorine starvation will also reduce the chlorides in the urine as one might expect, but strange to say, only for the first day of privation! If the chlorine-free food and drink be continued, the elimination of the chlorides in the urine will be as great on the third day as before the experiment began, and may continue for a time at the normal point till the store of chlorine retained in the body becomes exhausted when it will begin gradually to fall. Picard assures us that the blood of the dog contains as much chloride during the starvation period as in normal health and liberal feeding.

The foregoing experiments are physiological, and were observed in healthy animals. We will now compare the pathological results and examine how far they agree in general or coincide in detail. Commencing with anæmia, whether primary or secondary, we find that there is a retention of chlorides somewhere, for they disappear from the urine. Sticker and Hübner found in gastric carcinoma that the average Na Cl for four days was 1.55 in 31.2 grammes of urine. Stroh gives daily averages in the same disease of 0.34, 3.37, 0.24, 1.7, and 0.66 grammes Na Cl. Gaestig in carcinoma of the œsophagus gives an average of nine days as 0.44 grammes of Na Cl in the urine—11.5 grammes being the normal amount. In ulceration, as for example in uterine carcinoma, with a daily discharge of 269 and 320 cc. the Na Cl was found to average 1.15 per cent. Moraczewski tells us that when the blood is poor in Na Cl and the elimination in the urine is small, recovery is probable. It is worthy of note that the chlorides remain normal in uncomplicated gastric ulcer and in nervous dyspepsia with hyperacidity. In such cases, when the ingestion of chlorides is great, and the elimination low, pyloric stenosis or gastric ectasia may be suspected. From these phenomena we have been led to infer that the absorption of chlorides is small, and in general inanition the body stubbornly resists depletion of the chlorine store.

The amount of Na Cl present in the blood during any of these pathological conditions is a matter of considerable controversy owing to the varying results in each disease. Freund and others found in the case of anæmia an increase of phosphorus and a diminution of Na Cl (0.169 per cent. of phosphorus against the normal 0.088 of a gramme, while the chlorine was 0.178 per cent. against 0.307 per gramme). In carcinoma Moraczewski found the chlorine to be 4 per cent. of the dry substance; in anæmia the chlorine increased with the progress of the anæmia and in proportion to the diminution of the phosphorus. It seems that the chlorine is retained in the same sun ratio as the anæmic noxa, and is stored up in the organism in place of phosphorus and calcium in the blood and various organs of the body, and this view is supported by analysis of the organs in which 0.20 per cent. was present in the fresh state. It is supposed that during life the morbid condition alters the constitution of the fluids in regard to their salts, but this hypothesis falls through in pneumonia although plausible in anæmia.

Biernacki challenges these results, and maintains that the blood has a constant amount of Na Cl under all conditions although there are temporary alterations in quantity in the urine and stomach. This opinion is rather supported by the analysis in the "carcinomatous constitution of the blood" which is unaltered although the elimination by the urine is very small. Nasse has discovered that the cancerous tissue retains a larger quantity of NaCl. Landenheimer thinks that the saline watery retention is not the specific cause of the cancerous metamorphosis but is rather accidental, and may be the result of nephritic or circulatory disturbance. Along with pneumonia Unruh finds that relapsing fever and typhus equally reduce the chlorides, although typhoid does not. It cannot be altogether due to fever that pneumonia retains its chlorides because malaria fever causes a larger discharge of Na Cl during the fever, as much indeed as six grammes in the first few hours of the high temperature is often eliminated. This is not a common result of malaria, as during the first twenty-four hours of the fever the chlorides remain stationary, but gradually increase till six grammes in an hour are produced; after this it gradually falls again till the fever disappears, when the chlorides again become normal. This apparent paradox to the pneumonic state can only be explained on Kast's hypothesis that the red corpuscle is at fault in the malarial state. Rem, Picci, and others assume that there is a higher pressure in the vessels of the kidneys that leads to the excessive elimination in malaria.

Munelli and Giudice maintain that there is a parallel between the elimination of urea and the sodium salts in fever. His experiments were conducted in articular rheumatism, pleurisy, parenchymatous nephritis, and pneumonia. In all these febrile conditions the fluctuations of chlorine and urea elimination were parallel; but an exception must be made when the patient was fed entirely on a vegetable diet, the chloride being diminished, while urates were increased. Leyden's opinion is that the tissues are more fluid in the febrile state from the retention of water, and that more sodium chloride is required to saturate the increased proportion of fluid.

Very few investigators agree with Klees in the theory of a renal affection; although in cases of nephritis from carcinoma, or heart disease, the elimination of chlorides was reduced, while the chlorides in the liver were found to be increased after death from uræmic coma, which led to the inference that the retention of chloride was the cause of the coma. In acute attacks of lead poisoning the proportions of both water and chloride is reduced, the latter relatively less than the former. In chronic cases, however, the converse is true, elimination of both being greater than in health, but the relative quantity of the chlorides is still in excess.

We now come to the final channel of elimination, the skin, concerning which very few experiments are on record. Fodor observed in a case of pemphigus, when making an analysis of the urine, that the chlorides only amounted to a fifth of the normal quantity. Brueff, on the other hand, affirmed that in cases of prurigo the quantity of chlorine eliminated was very great, while control experiments seemed to show that the chlorine balance is maintained. To further test the accuracy of these statements I have personally devoted a considerable time to experiments on prurigo, psoriasis, and chronic eczema, and with this object in view I attempted to eliminate every probable fallacy by carefully measuring the intake and output at the different emunctories, not omitting the fæces as Brueff and others have done. By this means I was able to observe the variation of the chloride balance in the physiological healthy person before advancing to the pathological. The result of my pathological examinations were in accord

with Brueff's, who found a large excess of Na Cl in the urinary secretion. In the ordinary physiological condition, when compared with the pathological state of prurigo and chronic eczema, under similar conditions and the same food, both as to amount and quality, was as 15 to 25 or as 20 to 30, or an increase in elimination of 50 per cent. There is another point worthy of noting that in the healthy the elimination of Na Cl is regular, while in the pathological it is not so, although the administration of the substance is the same in both. If we take from among many others a case of chronic eczema which was carefully observed for four weeks both as to ingesta and elimination, the average excess of Na Cl elimination was four grammes more than the healthy control subject. Another, commenced on February 4th, and ended on March 8th, gave a total of 825.6 grammes of Na Cl in the urine while the healthy control subject gave only 713 grammes, thus giving an excess in favour of the diseased subject of 112.6 grammes. It must be remembered that the daily averages of these two subjects are very different, and may account for many of the errors published, as the experiments may not have been continued sufficiently long to eliminate this error. The curve of the healthy subject, when represented diagrammatically, has a wavy character, with regularly graduated rising and falling, while in the pathological subject it runs up and down very abruptly.

In conclusion it would, perhaps, be safer not to elaborate any new theory, but to support one of those already acknowledged, viz., that the retention of chlorine is a temporary accumulation in the fluids of the tissues, and that the skin is a functioning depot over a succulent area. In other words, up to the time of the pathological changes in the skin so long as the neighbouring tissues are well moistened with fluid, the elimination of Na Cl will be large, but will suddenly sink on the first invasion of the skin affection, if the surroundings become less moist and the supply of chlorides be not increased.

To maintain this balance two factors are necessary, viz., the supply of chlorides and the presence of fluids, a point which may possibly be found of practical value in the clinical treatment of the case when the patient may be rapidly declining from salt starvation.

Transactions of Societies.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF OBSTETRICS.

MEETING HELD FRIDAY, APRIL 20TH, 1900.

The President, Dr. A. V. MACAN, in the Chair.

EXHIBITS.

DR. FLYNN exhibited a specimen of ovarian tumour without any uterine attachment at the time of operation.

Dr. SMYLY said it was interesting because of the impossibility of making a diagnosis. What struck him as peculiar was that the tumour was in the upper part of the abdomen, and there was a clear, resonant space immediately over the pubes. He agreed with Dr. Flynn's view as to the cause of the condition—viz., that the tumour was pushed up into left hypochondrium, and formed adhesions there, and as the uterus afterwards descended into the pelvis there was a drag on the pedicle, causing atrophy and complete separation from the tumour. There could hardly have been twisting of the pedicle, because it would have given rise to violent symptoms.

Dr. MACAN said that if the only adhesions were to the omentum, and if the omentum were quite free to come back, he could not see how the separation could have taken place by traction.

Dr. GLENN exhibited a specimen of uterus removed

by retro-peritoneal hysterectomy for persistent hæmorrhage.

Dr. TWEEDY asked why Dr. Glenn selected the abdominal instead of the vaginal route for the extirpation of the uterus?

Dr. MACAN thought it was a case in which atmo-kausis might have been employed.

Dr. GLENN, in reply, said he selected the abdominal method because of the inflammatory condition. Taking everything into account, he thought it was better that the operator should be able to see what he was doing. He did not employ atmo-kausis because he found it never cured myoma.

FIBROMA SPRINGING FROM THE ILEUM, FORMING A TUMOUR IN DOUGLAS' POUCH, REMOVED BY CELIOTOMY.

Dr. KIDD exhibited a specimen of a pure fibroma which sprang from the muscular layer of the ileum, and had by its weight dragged a loop of that intestine down into Douglas' pouch. Here the tumour was adherent to the rectum. The adhesions at the time of operation were separated, and the tumour, along with the portion of ileum, brought outside the abdomen. The tumour was removed by a longitudinal elliptical incision about 1½ inches long and ½ inch broad. Both the appearance of the intestine and, what was of more importance, the feeling of the intestine—revealing it to be perfectly normal—no portion of gut was resected. The opening in the intestine was then closed by a double line of transverse Lembert sutures, so as not to diminish the lumen of the bowel. The patient made a very good recovery. A slide under the microscope showed the tumour to be a pure fibroma. One of the chief points of interest in the case is that such a tumour in the pelvis may increase our difficulties of diagnosis greatly. The tumour was about the size of a medium-sized orange. When Dr. Kidd found that the tumour was intestinal he handed it over to Dr. Heuston to finish the operation.

Dr. TWEEDY said that 19 out of every 20 tumours growing from the intestine were malignant, and the majority of men in such an operation would have removed six or seven inches of the bowel on either side. Dr. Kidd appeared to have decided that the tumour was not malignant at the time of operation.

Dr. KIDD, in reply, said that the line of demarcation of the portion from which the tumour was growing was clearly drawn, and the feel of the intestine all round was proof that it was normal.

SHORT NOTES ON A CASE OF ROUND-CELLED SARCOMA OF BOTH OVARIES, WITH SPECIMENS, PHOTOGRAPHS, AND MICROSCOPIC PREPARATION.

Dr. KIDD, after reviewing the literature of the subject, drew attention to the extreme rarity of these tumours, having failed to find any account of a similar tumour being brought before that Section, and also failing to find any authentic record among the proceedings of the older Obstetrical Society, or among the Transactions of the old Pathological Society. The patient was 39 years of age, was much wasted, the wasting extending over 12 months, she says, although she only noticed the enlargement of the abdomen. When the left ovary was being removed there was quite alarming hæmorrhage from the pedicle, owing to its cutting through with the ligature. The tissues were infiltrated with disease, although there was no naked-eye extension to the uterus. Finally, after great difficulty, the pedicle was secured. The difficulty of dealing with the right ovary was not so great. The peritoneum and pelvic glands were found infiltrated with the disease. The abdominal wall through which the incision was made was not a quarter of an inch thick, and no sign of muscle could be detected, owing to emaciation and probably separation of recti. She recovered well enough to be able to sit up for a day or two, but gradually sank from extension of the disease in the abdominal cavity and a large gland at the base of the neck on the left side. Dr. Kidd performed the operation with the hope of affording the poor woman some little relief from her desperate condition, and the fact of the wound being found perfectly united on the 10th day after the opera-

tion is, he thinks, an indication that the operation did not in any way hurry the unfortunate final.

Dr. SMYLY thought the most important point was to get absolutely clear of the disease if possible. If a microscopist were present at the operation, so that specimens could be examined on the spot, the operator could give a fair guess as to whether he had got outside the disease.

Dr. COLE-BAKER said he had assisted at the operation, and he thought Dr. Kidd should be congratulated on his extreme pluck in removing the second ovary.

Dr. MACAN said it would be interesting to know whether there was less danger of return in spindle-celled sarcoma than in the soft variety; also whether there was greater likelihood of general infection in a case of malignant disease of both ovaries than where only one ovary was affected.

Dr. KIDD, in reply, said he thought there was a better chance in the spindle-celled than in the other variety. It would be much more favourable if only one organ were affected. Where the two were engaged there was probably some general cause at work. Whenever the disease was found extending beyond the ovary the case ended disastrously.

Dr. COLE-BAKER related a case of "Porro's Operation for Ruptured Uterus complicated by Myoma," which is published in full on page 522.

Dr. KIDD said it was rather difficult to understand how it was that after a great many efforts had been made to relieve the uterus it went back almost by accidental manipulation. He could not account for the rise in temperature, especially as there was no evidence of suppuration.

Dr. SMYLY said he could not help thinking that the cause of the fever was in the tumour, because it disappeared immediately after the removal of the tumour. As to the reduction of the tumour, probably the greater portion of it had been pushed above the pubes by previous attempts, and it was only a coincidence that it went up during Dr. Fleming's manipulation.

Dr. MACAN agreed that the tumour was the cause of the temperature. He did not think there could possibly be a question of rupture in the ordinary sense. If it had been ruptured where was the hæmorrhage? He thought labour itself might be sufficient to so separate the tumour from its surroundings as to cause it to become a dead body, which might become infected from the rectum.

Dr. COLE-BAKER, in reply, said that from the ease with which the tumour was replaced he did not think there could have been any adhesions. There was no trace of hæmorrhage into the abdominal cavity, or of broken-down adhesions in Douglas' pouch or to the intestines. As to infection from the rectum, the same suggestion was made at the Clinical Club, but it was pointed out that before the occurrence of infection there would have been some adhesion.

The Section then adjourned.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD WEDNESDAY, MAY 2ND, 1900.

Mr. G. A. MILLER, President, in the Chair.

LAMINECTOMY.

Mr. COTTERILL showed a patient after laminectomy for paralysis of two years' standing, the result of spinal caries. The symptoms of spinal mischief began when the patient was at 36, and signs of pressure on the cord developed rapidly. For six months before the operation there had been complete motor and sensory paralysis of the lower half of the body. There was incontinence of urine and feces, and two large bed-sores had appeared on the buttocks. There was also cystitis. As counter-extension had given little relief, operation was decided upon, and the laminæ and spines of the eighth, ninth, and tenth dorsal vertebrae were removed. It was then found that pressure was due, not to granulation tissue, as was usually stated to be the case, but to exostoses springing from the bodies and arches of the vertebrae, which narrowed the spinal canal

down to the diameter of a large quill. Improvement was manifested 16 days after the operation, and the patient progressed steadily until he could now (a year after the operation) walk about with the aid of two sticks, and had complete control of his bladder and bowel.

Mr. SHAW McLAREN showed (1) Carcinoma of the Stomach and Esophagus, after Gastrostomy; and (2) Bilateral Fracture of the Scapoid Bone of the Carpus.

Dr. W. G. AITCHISON ROBERTSON read a paper on

THE ACTIVITY OF THE SALIVA IN DISEASED CONDITIONS OF THE BODY.

In order to eliminate the fallacy which might arise from the hourly variation in the diastatic power of the secretion, the experiments were always performed at the same hour. After the mouth had been thoroughly washed out all the saliva secreted during half an hour was collected, 2 cc. of the saliva was then mixed with 10 cc. starch mucilage at a temperature of 38° C., and the mixture was kept at this temperature for 10 minutes. The action of the saliva was then checked by boiling, and the amount of sugar which had been formed was estimated by titrating with Fehling's solution. The normal average of sugar formed was taken at about '08 gramme. He had examined the saliva in about 100 cases of different diseases. In chronic gastric catarrh the amount of sugar formed varied from '078 to '1 gramme. In acid dyspepsia the amount was increased, while in gastric ulcer it was diminished, and in dilatation of the stomach the diastatic action of the saliva was almost entirely in abeyance. In cirrhosis the amount of sugar formed was not diminished; it was occasionally largely increased. In most diseases of the lungs the salivary ferment was fairly active, '087 gramme of sugar being the average amount formed. In pneumonia the amylolytic action of the ferment was above normal before the crisis, below normal after it. In phthisis and in heart cases it was about normal. In many nervous diseases a subnormal amount of sugar was formed, 41 per cent. of the cases examined giving low readings. In one case of cerebellar tumour practically no diastatic action was present, while in a case of tabes, '11 gramme of sugar was formed. Two cases of Addison's disease gave subnormal amounts; one exceeded the average. In kidney disease the general average was low in fully 55 per cent. of the cases. In diabetics, a great excess of sugar was formed. In rheumatism, the amylolytic action was about normal, and the same could be said of anæmia, unless dyspepsia was present, when it was reduced. The amount of saliva varied considerably in different diseases. It was diminished in febrile conditions, chronic gastric catarrh, gastric ulcer, ascites, diarrhoea, chronic phthisis, heart affections, chronic Bright's disease, anæmia, chronic rheumatism, and Addison's disease; it was fully up to the normal, or increased, in acid dyspepsia, bronchitis, the early stage of pneumonia, and many cord affections. In many cases in which the saliva was scanty the amylolytic power was also feeble, while when the secretion was abundant the action was powerful. In fevers, however, the diastatic power was great, even when the amount secreted was scanty. In cases where the activity of the saliva was defective starchy food should be administered with caution, and ought to be pre-digested, partially at least, with malt or taka-diastase.

The paper was discussed by Drs. Harvey Littlejohn, Wm. Hunter, Ritchie, and Church.

Dr. CLAUDE B. KER read a paper on

"CROSS-INFECTION," SO-CALLED, IN FEVER HOSPITALS.

By cross-infection (for which the Edinburgh City Hospital had a bad reputation) was meant the contraction by a patient of a disease other than that for which he was admitted, the new infection having come from some other patient in the hospital. The figures for the last year were as follow:—Of 1,034 cases of scarlet fever, 38 (3·6 per cent.) took measles, and four (·38 per cent.) took chicken-pox; of 331 cases of measles, eight took scarlet fever; and of 147 cases of diphtheria, four took scarlet fever. The cross-infection in the measles and scarlet fever cases was higher than

the average; that of the diphtheria was about the normal. Of 472 cases admitted with other infections, none were newly infected in hospital. While there must always be some slight risk of cross-infection in a fever hospital from mixing of the nursing staffs of the different wards, and from the medical officers passing from one ward to another without satisfactory disinfection, Dr. Ker thought that this was insufficient to account for all the cases. In the City Hospital the measles ward was immediately below the typhoid ward, and might almost be said to ventilate directly into it, yet no case of measles had occurred among the typhoid patients. The real cause of cross-infection was importation of infection from outside, and this might arise in at least three ways:—(1) Incorrect diagnosis. (2) The co-existence of two diseases, only one of which had been diagnosed; within the last three months they had had 12 cases where the patient suffered from two infectious diseases simultaneously. (3) The admission of a patient suffering from one disease and incubating another. No fever hospital could expect to remain free from such accidents.

The paper was discussed by Drs. Harvey Littlejohn, Ritchie, Ronaldson, Webster, Dowden, Normal Walker, Lundie, and James Carmichael.

HARVEIAN SOCIETY OF LONDON.

MEETING HELD TUESDAY, MAY 8TH, 1900.

The President, Mr. W. H. LAMB, in the Chair.

THE SELECTION OF CASES FOR ABDOMINAL SECTION.

MR. ALBAN DORAN considered that these reports of bad cases were far more trustworthy and instructive than statistical tables of triumphs in abdominal surgery. Exploratory incisions for what proved to be irremovable malignant disease were dangerous unless the surgeon trusted to his eyes and kept his fingers as much as possible off the affected structures. When a malignant tumour was removable the separation of intestinal and parietal adhesions in itself involved peril, for a raw surface bearing a trace of malignant tissue was often the starting point of general septic infection. In cases of acute torsion of the ovarian pedicle immediate operation seemed to be the safer course as Wiltshire and Tait's well-known cases testified. He himself had recently operated where there was bilateral torsion, removing a pair of dermoid cysts. Had he delayed, extensive adhesions would have formed, a special source of danger in operating on cysts with greasy contents.

Mr. BUTLER-SMYTHE thought that exploratory incisions might be more frequently employed in doubtful cases. If the operator confined himself to a small incision, little harm would be done to the patient, whilst the diagnosis would be made almost to a certainty. On the other hand, if the surgeon opened the abdomen, broke down adhesions, handled the abdominal and pelvic contents, and in the end failed to remove the cause of trouble, then the patient's life was placed in jeopardy. He, Mr. Butler-Smythe, wished to emphasise the fact that exploratory incisions and exploratory operations were two very different matters, the former being almost harmless, the latter decidedly serious. He was much interested in the case mentioned by Mr. Malcolm, "where a patient who had a malignant ovarian tumour died from heart disease after simple tapping." Three somewhat similar cases were known to him. One occurred in his own practice after removal of a sarcomatous tumour of the ovary, the other two in the practices of two well-known operators. Curiously enough in all four cases no post-mortem examination could be obtained, but so far as could be judged by the symptoms noted in each case, the fatal termination was undoubtedly due to heart failure, the attacks coming on suddenly when the patients were fairly on the way to convalescence. These cases led Mr. Butler-Smythe to believe that the malignant condition had more to do with the sudden deaths than was generally imagined. Mr. Malcolm's paper was an example that might well be followed by other surgeons with benefit to their patients and to themselves.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, May 19th, 1900.

MONSTROSITY.

M. LANNELONGUE presented at the meeting of the Académie de Médecine a Hindoo boy, *æt.* 8, well developed, but who had attached to the epigastric region a body without a head, constituted by a trunk and four limbs incompletely developed. The palpation of the parts revealed a certain number of vertebræ, the iliac bones, and a rudiment of the skeleton of the limbs. No trace of intestines could be found, but the sexual organs, which were that of the male, were somewhat developed, and both subjects urinated at the same time. The speaker believed that the pedicle contained no vital organ, and consequently an operation might be attempted, but the consent of the Barium was not easy to obtain.

ANÆSTHESIA BY COCAIN.

Professor Tuffier has published a very interesting account of operations done by him under the influence of general anæsthesia produced by injections of a solution of cocain under the arachnoid of the medulla. He operated in this way on 63 patients with complete success, and his operations were of the lower limbs, the perineum, rectum, abdomen, genito-urinary organs, external and internal of both men and women. For the operation he uses an ordinary Pravaz syringe, but the needle is of a special kind—it is made of platinum, and two-and-a-half inches in length and the point bevelled. The solution of cocain that he employs is 2 per cent. in strength; it is sterilised and of recent make. The patient is placed in the sitting posture with the anus placed in front. The lumbar region is rendered aseptic by soap and water and subsequent washing with alcohol. The iliac crests being taken as points of repair, a line is drawn between the two passing across the lumbar vertebræ (spinal apophysis), the penetration into the medullary canal is under this line. The index of the left hand marking the spinal apophysis, the patient is told to incline the body strongly in front so as to render the lumbar region prominent. A separation between the fifth and sixth vertebræ, of nearly half an inch is thereby effected. At this point of the operation, Prof. Tuffier warns the patient that he will cause him very slight sharp pain and he is to keep still. Seizing the needle, only with the right hand, he passes it in on the right of the vertebral column at a quarter of an inch of the line and close to the index placed on the apophysis; the needle thus passes through the skin, cellular tissue, lumbar aponeurosis, the sacro-lumbar muscles, the aponeurosis of the quadratus, and finally reaches the rachidian canal through the fellow ligament. If the needle is really in the sub-arachnoid space, a few drops of clear yellowish liquid escapes (cephalo-rachidian liquid); the surgeon should not inject the cocain before he could see this liquid oozing out.

The syringe, at this point, is filled with the two per cent. solution, is adapted to the needle, and the injection is slowly poured in, drop by drop, as it were, until half the syringe is employed—that dose should not be exceeded. At the end of from four to ten minutes the

patient experiences a sensation of pins and needles in the legs and numbness, mounting up in some cases to the axilla. The moment has arrived to operate, for the *analgæsia* is complete and *absolute*, and lasts an hour and a half. In this way M. Tuffier was able to anaputate at the thigh in several cases, and the patients interrogated said they only felt a sensation of contact. One of them, hearing the sawing of his femur, said he did not know whether it was his leg or that of the table that was being cut. A woman who had the uterus removed per vaginam said after the operation that she felt at the time that the uterus was being pulled forwards, that something got unhooked, but she felt no pain.

In the course of lumbar nephrectomy, when the operation was about to terminate, the patient asked the operator when he was going to begin!

As to the toxic effects of the cocain, M. Tuffier says that they are always slight and give no cause for anxiety. In general, the patients complain of a certain sensation of weight in the epigastric region, followed in most instances by vomiting; headache is also more or less felt, while sweating, some dilatation of the pupils, trembling in the limbs, and rapid pulse have been remarked. But never did the Professor meet with any grave accident.

Of the 63 persons operated on by this method, 39 were men and 24 women, and the ages ranged from 12 to 69. Of these operations I mention the following:—Resection of the knee, amputation of the thigh and the leg, nephrotomy, hypospadias, lithototry and cutting for stone, hysterectomy, laparotomy, extirpation of the rectum, hernia, appendicitis, &c., &c. The patients while under operation were apparently indifferent to what was being done, and talked freely and rationally with the assistants.

In conclusion, M. Tuffier says that the method should not be employed with children or hysterical persons, and that if in the course of the primary operation some incident occurred which prevented the anæsthesia from being produced, ether might be given at once without the slightest danger.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, May 19th, 1900.

At the last meeting of the Society for Innere Medizin Hr. v. Leyden showed a

PECULIAR CASE OF APHASIA.

The man had been in his klinik from February 19th, and suffered from right hemiplegia. He was not syphilitic, and had suffered no injury to the head; was not a drinker. At Christmas, 1898, during the night, after he had already been asleep, he became unconscious, and in June, 1899, gradually-increasing paralysis of the right side was established. The patient was then treated for a time at Friedrichshain, and later on in an infirmary, and allowed home at the end of 1899 at the request of his wife. Then he had convulsions and attacks of excitement, so that he was taken to the Charité. Along with the hemiplegia was a peculiar form of aphasia. The power of speech was extremely limited

when admitted. He could only say Jungen, ja auch and Clara (the name of his wife), could not read writing aloud, but noted that his name was written wrongly on the board. He did not understand simple orders, but showed a great inclination to sing. His musical talent was not lost; the memory for melodies was complete, and he could sing them quite connectedly. This was not new, and the speaker had himself known a man who suffered from embolic hemiplegia who sang the most beautiful melodies. The present case was characterised by the fact that the patient sang the words of his songs and pronounced them distinctly, whilst otherwise he could scarcely get out a word, and could not name objects shown to him. He now sang the following songs: "Morgenroth, Morgenroth," "Ich hatt' einen Kameraden, O Strassburg, O Strassburg," with clear and distinct utterance, and several verses at a time. For an explanation of the phenomenon the hypothesis had been advanced that the centres for music and speech were identical, but followed parallel tracts. The sound went to the word centre and the music centre. It must be assumed that a connection existed between the auditory centre, the word centre, and the music centre.

Hr. Lazarus asked if the patient could sing a melody from notes? In a patient of his own this was the case, whilst he could not sing a tune after any one.

Hr. v. Leyden observed that his patient could not read music.

Hr. Paul Mayer gave a note on

NATURAL ANIMAL GASTRIC JUICE IN ACHYLIA GASTRICA,

and showed a case in which this had been employed. The patient was a man of 67 in whom no symptom pointed to a stomach affection. Four years ago he suffered from diarrhoea coming on four to six times a day. The speaker emphasised the importance of examining the contents of the stomach in such cases of diarrhoea, and by suitable diet bringing about an improvement that would not be got by astringents. He ascertained how far the different foods were used up. In the case before them, as was to be expected, he found the digestion of albumen very defective, as 17 per cent. of it was lost, whilst the absorption of fat was normal.

He made use of natural dog gastric juice after Pauloin's method as used in St. Petersburg. A gastric fistula was formed on the animal, and the oesophagus closed, so that when fed the food did not enter the stomach, but a large quantity of clear gastric juice was poured out and this was collected. HCl pepsine treatment had not been as successful as was expected, the reason being that the stomach did not perform so much chemical work as had formerly been attributed to it. Better results might be expected with animal gastric juice. The good effect was here shown in an examination of the faeces. The patient had the same food as before, taking 200 grm. of the animal gastric juice. The result was that the man who before had two to three pultaceous stools daily, on the third day had only one firm normal stool. The using up of food was better, instead of a waste of 17.6 grm. nitrogen only 1.4 grm. were lost. He was not able to continue the experiments from them owing to lack of material, but with further opportunity he would continue his investigations.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, May 19th, 1900.

CAPUT OBSTIPUM.

At the "Gesellschaft der Aerzte" Foederl recorded the history of 12 cases of caput obstipum, or torticollis, which he had corrected by operation. His method of plastic operating in these cases is to divide all the attachments along the clavicular and sternal margins. After correction the sternal ends of the muscle are held in apposition by catgut sutures. The result in all the cases was perfect.

THE BLOOD IN SYPHILITIC PATIENTS.

Losdorfer gave a short history of his examination of the blood of 125 syphilitic patients. During the first four or five weeks he could discover no change in the blood that the syphilitic germ had produced. At least no change could be found with the aid of the microscope when compared with the blood in the healthy. With the commencement of the glandular swelling the serum begins to diminish, the corpuscles elongate and swell with apparently a duller lustre. In a hanging drop a 100 or more will be found adhering with a to-and-fro as well as a dancing movement. The nuclei are distinctly larger, sometimes rugged or in patches. After the administration of mercury the numbers are rapidly reduced.

Paltauf considered the changes in the nuclei were due to degeneration or coagulation probably induced by the altered condition of the blood, and may be in some way connected with the outbreak of exanthematous eruption.

Kaposi questioned if the changes in the nuclei were of any aetiological importance in syphilis. As yet we had far too few control experiments to arrive at any accurate judgment on the matter. He had no doubt that more accurate examination of the blood would reveal definite changes, but the results, as far as we have gone, are not satisfactory.

STRUMA.

Preindlsberger next brought forward a young girl, *et. 15*, on whom he had operated for struma parenchymatosa. He removed the right half and isthmus of the thyroid, dislocated the left half towards the centre, where he divided it and left to shrink, which eventually occurred. The painful symptom of tracheal stenosis immediately disappeared after the operation.

MODERN ARMS AND SURGERY.

Habart followed with a paper on the surgery of modern wounds on the battle-field. Deaths from infected wounds was greatly reduced by the liberal use of disinfectants. He considered the mortality did not exceed 1.5 per cent. In order to examine this infecting power more carefully he used rifles coated with sterilised gelatine, and found it in the wound. Any poison could be carried the same way. He thought it worthy of note that 25 per cent. of the injured died, 20 per cent. were severely injured, while 55 per cent. were slight. The principal point to be observed is ambulance service and nursing, as well as sanitary arrangement. For accuracy and expedition the electric light is indispensable.

CARBONIC ACID BATHS.

Winternitz showed an "Ombrophor," which is a sort of douche apparatus for applying carbonic acid gas to the body under any pressure. A motor and distributor are

combined in a cylinder with sufficient for 25 douches. The cylinder has a pressure of 150 atmospheres.

Lang said that he had used the common soda water bottle with an indiarubber attachment and a fermenting agent in skin diseases such as chronic eczema, pruritus, &c., with surprising success.

Gartner thought this soda water bottle arrangement had been abused as "klysma" and vaginal douches.

ACTINOMYCOSIS.

Sternberg demonstrated cultures of actinomycosis taken from man through the air. The cultures were made from the air of the room and transmitted to ulcers on animals, where the bacilli were again propagated, but without lymphatic swelling, as in the original.

These anaerobic cultures cannot be made on Loeffler's diphtheria media. The best media is in anaerobic cultures of saccharine bouillon. The clinical appearance of this anaerobic bacteria resembles in every detail the anaerobic forms of actinomycetes. He also found anaerobic streptococci in the lung along with the actinomycetes, which could be transmitted to the animal.

Continental Notes.—The Savoy Spas.

[FROM OUR SPECIAL CORRESPONDENT.]

NO. II.—AIX-LES-BAINS.

Aix has all the advantages desirable for a thoroughly successful health resort. A most picturesque situation; valley, lake, and mountains combining to increase its loveliness. A climate restful and delicious. Pure atmosphere. Go which way you will, interesting excursions near and far. Added to its natural advantages are all the resources of a city life hotels, pensions, villas, and apartments of varied excellence and prices; two Casinos with daily musical performances and theatrical representations unsurpassed at any summer resorts on the Continent. Good society all through its "season" (April to October); churches, libraries, reading-rooms; golf, tennis, balls, and all descriptions of social *distractions*. Many good physicians; and sulphurous waters of high excellence and overflowing abundance.

The months of the "English seasons" (April, May, June, and September), are the quietest and most pleasant. The months of July and August (the "French season") are the most fashionable. Of all the year, June is the supreme month. Superb weather, neither too hot nor cold; the verdant valleys and wooded hills of Savoy, and the snow-covered heights of the Dauphiny Alps in their greatest beauty.

The most valuable advantages of Aix are necessarily its mineral springs, two of these supplying the extraordinarily large quantity of over four-and-a-half million litres (say 1,125,000 gallons) of sodi-calcareo-sulphuretted water, having a temperature of 112° to 117° F., every 24 hours. It is claimed that these Aix thermal waters possess an unusual unctuous quality which particularly adapt them to rubbing and kneading processes; and that to this should be attributed at least a part of the unquestionable success of the Aix massage treatment. Part also of this success may be due to the acknowledged skilfulness of the Aix *masseurs*, some of whom have inherited from parents and grandparents their knack and method.

The bath establishment, with its recently-completed improvements, is to-day one of the best in Europe. Its swimming baths, with constant flow of the sulphurous waters, are very popular. Its vapour and humage cabinets, Berthollet and local douches, stoves, inhalation-rooms, pulverisations, &c., include the latest, most complete, and approved equipments. The massage-douches are unequalled, as the continuous abundance of the heated water, its temperature, the graduated pressure ever at the operators' command, and (as said before) the experienced skilfulness of the *masseurs*, are unique. The two chief diatheses for a course of treatment at Aix are:—

1. Rheumatism, with its kindred complaints; neuralgia, gastralgia, sciatica, heart diseases.

2. Chronic gout; especially articular manifestations.

In gouty cases Aix achieves most success where cutaneous eruptions appear; also, where passive swellings and stiffness follow the attacks; and where there is no portal congestion. For rheumatoid arthritis, Aix far exceeds all other Continental Spas. It is also claimed that the Aix treatment is highly beneficial in catarrhal complaints (respiratory, digestive, urinary), chronic ulcers, caries, sprains, wounds, fractures and all bone troubles. Nervous affections, skin diseases, paralysis, atrophy, anæmia, pulmonary phthisis, &c., &c.

The Operating Theatres.

ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.

CATARACT OPERATION.—ATTEMPT AT THE AVOIDANCE OF SECONDARY NEEDLING.—MR. H. WORK DODD operated on two cases of senile cataract. First case, a man, æt. 60, who had been admitted for well matured cataract. The patient was placed on the ordinary high ophthalmic operating table, and the ordinary incision (3 mm.) made with a Graefe's knife; a good-sized iridectomy was then performed, and the anterior capsule of the lens opened in the T fashion, and the lens carefully removed by pressure being applied from below upwards by one scoop, and the posterior edge of the wound being controlled by another, the eye being as it were squeezed gently between them; the cataract came slowly, but the pace of its advance being carefully graduated by the method of the application of the scoops. The eyeball was then firmly seized close to the cornea by toothed forceps, and near the forceps a cataract needle was passed through the cornea in such a position as to leave the wound or scar so as to be hidden by the upper eyelid; the posterior capsule was then carefully lacerated in a situation as is usual for the needling of secondary or capsular cataract, thus continuing the removal of the lens and the secondary needling operation into one sitting.

The second case was that of a woman, æt. 65, whose cataract was not quite so mature as that of the man, and was operated on in precisely the same manner, the only difference in the steps being that the smallest quantity of vitreous escaped at the moment of passing the needle through the cataract incision.

Mr. Work Dodd pointed out the object of his procedure, which was to do away with the secondary

needling of the senile cataract operation, thus combining the two operations into one sitting. The first case, he said, as far as the operation was concerned seemed to be perfectly satisfactory, it showed that it was possible to needle the posterior capsule without necessarily losing vitreous through the original open cataract wound, but he indicated that the capsule had been opened by a needle transfixing the cornea quite close to the grip of the toothed forceps thus avoiding the danger of passing the needle through the original cataract incision, which in his opinion must infallibly lead to loss of vitreous; also he pointed out that the cornea must be transfixed close to the grip of the forceps because after the removal of the lens and the accompanying loss of aqueous, the cornea and eyeball are so flaccid and non-resistant, that it is difficult to avoid squeezing out the vitreous in the act of penetration of the cornea. He supposed that the wound in the posterior capsule made by the needle did allow the passage of some vitreous into the anterior chamber, but this has probably kept from coming out of the eye in this case by the fact of there being altered intra-ocular pressure which probably existed, and by the filling up of the original wound by flaccid structures. The point of difficulty in the operation he considered to be the avoidance of loss of vitreous, and this he had endeavoured to effect by the plan he had followed, namely, transfixing the cornea itself out of the line of vision, instead of introducing a sharp needle through the original cataract wound. Of course, he said, the great object of the whole procedure was to more completely restore the patient's sight by removing all obstruction to vision at one sitting. To show how carefully and slowly the needle must be made, as it were, to steal into the capsule to avoid loss of vitreous, he pointed out that in the second case (in which the vitreous was not so matured), which was done with equal care, and by the same method in every step, he had lost the smallest quantity of vitreous through the original cataract incision, as a result of the gentle needling through the cornea.

In the first case the eye healed in a very favourable manner; the needling wound in the posterior capsule was distinctly visible and open six weeks after operation, but was yet veiled by a very thin membrane; the vision, however, was good, but would have to be improved by a later needling through the veil just mentioned. Mr. Work Dodd therefore considers that the conclusion is that in very mature cataracts where there is a marked dislike on the part of the patient to a second operation it is profitable to operate in one sitting by the above-described method, with probably an improved result in the way of vision.

The second case unfortunately, on the day after operation, developed a severe attack of influenza and pneumonia.

It is officially announced that the Tenth International Congress of Hygiene and Demography will be opened in Paris on August 10th, lasting until the 17th, under the presidency of Professor Brouardel, Dean of the Faculty of Medicine of Paris. Dr. P. F. Moline, 42, Walton Street, Chelsea, S.W., is the secretary of the British Committee. Further particulars will be published shortly.

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The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

WEDNESDAY, MAY 23, 1900.

THE MEDICAL MAN OF THE FUTURE.

It is of some interest to speculate on the future of medical practice as indicated by the trend of passing events in the professional world. Nor is such an inquiry altogether devoid of a practical bearing. Inasmuch as it may serve in some sort of fashion as a chart to heedless wayfarers. The key to the whole position may at once be found in the fact that medicine has not so far attained the position of an exact science. It is true that every year is adding fresh data and fresh generalisations to the store of accumulated knowledge, but a glance at the commonest diseases, such as rheumatism, gout and whooping-cough, will convince the most ardent enthusiast that a vast expanse of the field of medicine remains unbroken ground. This no-man's land harbours the quack and furnishes the charlatan with the opportunity of laying snares for the unwary. In the face of advancing scientific medical knowledge the practice of taking patent medicines must sooner or later vanish. The only possible excuse for a person swallowing physic of which the composition is kept a secret is that legitimate medicine has been tried in this particular case and found wanting. In other words, the failure of the physician provides the vantage ground of the patent drug vendor. To such an extent has the evil grown that some of our leading physicians do not hesitate to order in their prescriptions compounds of whose ingredients they are ignorant. Even in the present day there can be no reasonable excuse advanced on behalf of the medical man who acts in this feeble and illogical way. In the future it will be impossible for the responsible practitioner to countenance any secret remedy whatever. The State, moreover, will no longer accept toll for the

sale of patent medicines, nor will the educated citizen be content to leave the treatment of his bodily woes to men untrained in anatomy, physiology, pathology, materia medica and the general science and art of medicine. Indeed, by the time that millennium of universal enlightenment shall have arrived the time honoured practice of physic taking will have to a great extent died a natural death. The tendency is ever towards the prevention of maladies rather than to that systematic treatment of resulting symptoms which forms the *rationale* of the empirical system of medicine which we have hitherto been compelled to accept. Without any great stretch of imagination we may conclude that in a not distant future a coming generation of mankind will witness the universal extinction of all diseases that are preventible by measures of skilled hygiene. The rôle of the physician will then be to correct and mitigate the results of violations of the laws that govern a healthy existence. In addition to that demand upon his services he will have to attend to the effects of physical accident, and will always be required to exercise the obstetric art. Not only will the amount of disease be reduced to vanishing point, but the treatment of all morbid processes will become much more scientific, possibly along the lines indicated by serum-therapy, and the use of active principles of drugs instead of "blunderbuss" prescriptions of varying standards, and often of conflicting action. At the distant epoch which we are imagining the people will have learnt the lesson that they should pay the doctor for his judgment and experience, and not for his phials of physic. In other words, they will have acquired a fuller knowledge of that wisest of all saws which tells us that "Prevention is better than cure." The medical profession will then assume its proper position as the champion and herald of health for the nation and not as the patchwork restorer of damaged constitutions. Meanwhile, the history of medicine, whether in its pre-scientific or semi-scientific days, has been one of constant progress and of glorious result, and when that day of full knowledge arrives it will be the crown of a vast amount of silent and unrecorded toil. The knowledge that a great amount of unnecessary sickness remains in the world will be a never-ceasing impetus to the medical profession in its whole-hearted effort to benefit humanity.

MODERN VIEWS OF DIABETES.

DURING the last fifty years a vast amount of labour has been bestowed on the study of diabetes, its etiology, pathology and treatment. We have learned much, but the immediate result has been rather to show that glycosuria, or diabetes, terms which are not interchangeable, but which are often made use of in such a way as to provoke confusion, are more of the nature of symptoms than the expression of well-defined morbid conditions. We now recognise that diseases of very different organs and tissues may be associated with the presence of sugar in the urine so that its excretion does not necessarily imply any

particular disease. We are still in the dark in regard to the circumstances which render the tissues unable to dispose of the sugar which, in one form or another, finds its way into the body and thence into the circulation, and no theory yet suggested satisfactorily explains all the clinical facts. It must be premised that the sugar-consuming power of the tissues is a variable quantity. Each individual presumably has his own standard beyond which his organism will fail to dispose of carbohydrates. In the condition which is described *en bloc* as diabetes that standard is lowered, and when this reduction attains a certain degree it becomes pathological. When a given subject is able to assimilate sufficient sugar to provide for the actual needs of the economy the presence of sugar in the urine, as the result of a diet unnecessarily rich in this substance, may fairly be described as glycosuria. When his standard falls short of this limit he may be said to be suffering from diabetes. It must be borne in mind, however, that the reduction is relative and not absolute. We find, for instance, that while one diabetic patient is restored to a sugar-free condition by moderate dieting, the most rigid exclusion of carbohydrates in another will not attain the object in view. The most plausible explanation of this depreciation of the standard of sugar assimilation is that the liver, for some cause which remains to be explained, loses its power of storing glycogen, and that the tissues, gorged with sugar, are unable to consume that substance, the ensuing glycosuria ultimately becoming persistent. As Dr. Saundby pointed out in the address which he recently delivered at Cheltenham, it is by no means an easy task to furnish a clinical definition of diabetes which is both accurate and comprehensive. Until this can be done, however, we cannot promise ourselves that we are within measurable distance of a satisfactory knowledge of the disease. For the present it must perforce be defined as a disease associated with persistent or recurrent glycosuria which, sooner or later, is accompanied by thirst, polyuria and failure of nutrition. The inadequacy of this definition may be gauged from the fact that it does not enable us in a given case to decide whether it will or will not prove to be diabetes. Diabetes, moreover, presents itself under very different degrees of gravity. In some cases the symptoms clear up entirely, only to return, for reasons which we are utterly unable to appreciate, at a later period. In others again the disease, though persistent, runs a mild course for years without obviously getting worse, but even in these cases death may be unexpectedly precipitated by an attack of coma. In many cases no doubt diabetes is merely the expression of nervous breakdown or disorganisation, and this is especially probable in respect of the acute cases with a rapidly fatal termination. In others, as already observed, it is only an indication that the organs are unequal to the assimilation of more than a certain proportion of carbohydrates. It is very important to recognise to which class the individual case must be relegated, not only in view of prognosis but also of treatment.

Dr. Saundby very aptly insists in the fact that the presence of sugar in the urine is not of itself a sufficient justification for forthwith placing the patient upon the routine course of treatment. Before deciding this momentous question more or less prolonged observation may be necessary, and the first point to elucidate is the extent to which the power of assimilating sugar has been reduced. Then only can a rational line of treatment be decided upon without exposing the patient to the risk associated with enforced abstinence from an important category of alimentary substances.

NEW SANITARY ORDER FOR IRELAND.

ON the 16th inst., a most important and valuable series of orders for the future regulation of the sanitary administration of Ireland was issued by the Local Government Board. They are so voluminous that it is impossible for us to publish them, even in abstract, in the present issue. Their importance lies in the fact that they, to a great extent, give practical effect to the Irish Public Health Act of 1878 the beneficial provisions of which were deliberately and effectually squelched by the Local Government Board of that day. Some may recollect that that Act provided at least in a permissory sense, for the appointment of a Superintendent Medical Officer of Health for each union whose duty it would be to supervise the sanitary work of its Dispensary Medical Officers, and, in a general way, to keep the guardians stirred up with reference to the sanitation of their district, he receiving, of course, a commensurate salary for such work. This is the system which has brought the condition of English sanitary districts into so excellent a state, but the Irish Local Government Board of that date, with extraordinary audacity, decided to set the Act at defiance. It sought, by every means, to discourage the guardians from appointing a medical superintendent, and, to that end, it changed the title of the office to that of "consulting sanitary officer," with the purpose of preventing such officer from taking any action until he was consulted. Then they issued an order minimising his pay, in case any Board might be disposed to recognise its duty, by making such an appointment, and even went so far as to direct the guardians that they need not pay anything, save a fee whenever the superintendent officer was consulted, which, needless to say, he never was. At the same time the Local Government Board gave the dispensary doctor to understand that the less he troubled himself about sanitation the better for himself, and that he would be wise if he drew his miserable pittance of £3 or £5 a year, and said nothing about it. The Local Government Board of that day, in fact, to save itself trouble and responsibility, deliberately postponed the sanitary progress of Ireland for thirty years; and, in our opinion, a more nefarious transaction never emanated from a public department.

The order now issued draws the pen through the inaction of the past thirty years, and gives effect to the law of 1878 as Parliament intended it. It esta-

blishes a Superintendent Medical Officer of Health for each district—Rural or Urban Council—with such duties defined for him as, if he discharges them, will keep both guardians and dispensary doctors up to their sanitary trumps; and it specifies revised duties for all the officers concerned, from the highest to the lowest. We can only say that, at a first reading, we have nothing but approbation for this act of the Local Government Board. We shall endeavour to sketch the terms of the new arrangement next week.

Notes on Current Topics.

The Sick and Wounded from the War.

THE war toll in the form of sick and wounded soldiers is fast becoming a prominent feature of the campaign in South Africa. Besides those already incapacitated for further service who have reached this country, the daily papers report that transports will shortly arrive conveying no fewer than 3,808 more wounded and sick officers and men. Fortunately, the Government have ample resources upon which they can draw for the reception of this vast crowd of invalids; and it is satisfactory to know that however great such consignments from the front may be afterwards every provision has been made for their distribution among the hospitals in this country. One of the most melancholy features, however, of the campaign at present is, the enormous mortality from typhoid fever which is taking place at Bloemfontein. Presumably, everything is being done in order to prevent the dissemination of the disease, but in view of the fact that the troops were resting there for some weeks under favourable conditions, it is somewhat surprising that so many fatal cases of the disease should have occurred. Possibly the men were infected before they reached Bloemfontein, and like the Boer prisoners who were sent to Cape Town after Cronje's surrender, have fallen victims to previous privations. It must also be borne in mind in this connection that many thousand inoculations against typhoid fever were performed on the troops, and no doubt steps are being taken to collect statistics for a report, showing the value or otherwise of this alleged prophylactic measure. Such a report will be looked forward to with eager expectancy, inasmuch as this is the first occasion upon which the serum inoculation treatment against typhoid has been carried out on a large scale.

The Apothecaries' Society and the General Medical Council.

SINCE the last Session of the General Medical Council, Mr. Brudenell Carter has been replaced by Sir Hugh Beevor as representative of the Apothecaries' Society. This change will disappoint some who were anxious to hear Mr. Carter explain from his seat in the Council how he justified his denial of being the chairman of the committee that sealed poor Hunter's fate for calling himself an M.D. To

quote Mr. Carter's own words, he said: "I went to the meeting, I found two other gentlemen there, and they asked me to take the chair, and I chanced to occupy the chair at that time," notwithstanding this, Mr. Carter denied he was in the chair, for to quote him again "I was," he said, "not the chairman of the committee." There are many who give Mr. Carter every credit for trying to do what he thinks right, but his blindest partisans will find it hard to show that Mr. Carter was not chairman of that committee which decided on the disastrous prosecution by the General Medical Council of the late ill-fated Mr. Hunter, L.S.A. Whatever may be thought of the late representative of the Apothecaries' Society being a party to such proceedings against a member of the very body whose interests he was sent to safeguard, it may be confidently expected that the influence of Sir Hugh Beavor on the Council will be used on behalf of the licentiates of the body he represents, and not to their undoing.

A Warning to Medical Men.

LIKE all other classes of society, members of the medical profession find themselves exploited by special craftsmen. A transparent attempt of the kind has recently been exposed by the *Financial News*. It appears that a persuasive gentleman has recently been making the round, more or less, of medical men in the north of London. He first invites them to sign a type-written application for the post of medical examiner to a life insurance company. The scale of fees to be paid for examination of candidates varies with the amount insured, being one guinea for £100, and three guineas for £500. The next step is to induce the medical man to take up some shares in the insurance company, and a type-written application is presented for that purpose, such shares being payable in full upon application. The result of this ingenious attack would be that the medical man who fell into the trap would part at once, to a total stranger, with cash down, in the hope of obtaining some future return in the way of professional fees from a company of which he had never even heard, and which does not profess, on its own forms, to be registered. As medical men are notoriously apt to be somewhat lax at times in business matters it is desirable to give publicity to the pitfall which appears to have been prepared for them.

The Finances of the General Medical Council.

THE financial position of the General Medical Council and its branches will doubtless receive considerable attention this session of the Council. Many observers have noticed the great importance that is attached by the Council to the large committee appointed to report upon the affairs of the Branch Councils. The only section of the Medical Council in a really prosperous condition is the English Branch Council, which has advanced on a mortgage of the freehold premises of the Council, a very large sum to the parent body. The important question has, however, been raised to what

extent the Act of Parliament, under which the English Branch Council exists, confers the power on a Branch Council to transact financial business of this money-lending type, but that, it may be urged, is a matter more particularly for the individual trustees to investigate. There is no gainsaying the fact that the General Medical Council is being run at a loss and sooner or later the fact will have to be faced that its expenditure exceeds its income. As the expenditure is to a great extent automatic, the Council can exert very little control over the spending department, and the problem will shortly have to be solved, how to adjust the funds so as to meet existing and future requirements.

Insurance Companies and their Medical Officers.

A CORRESPONDENT has sent us for inspection a form for the medical officers' report, issued by the Equitable Life Assurance Society of the United States, which presents several curious points for comment. It is to be assumed that the society does not appoint medical examiners without taking the trouble to ascertain beforehand that they possess the necessary qualifications and are otherwise equal to the task to be entrusted to their care. Yet we find the most detailed instructions given as to how to auscultate the patient, how to tuck up the linen in the male and female respectively, with permission to have recourse to further disrobing and physical exploration, "at your discretion." Specific directions are then given as to the way in which the presence of albumen in the urine should be ascertained, for all the world as if this process might possibly have been overlooked in the education of the medical examiner. A question hardly suitable when addressed to a medical examiner is whether "if yourself in the business would you assure this subject for life?" and so on. Last, but not least, the medical examiner is required to furnish three references, though with what object in view is not stated, presumably of respectability. These precautions may be necessary in the United States, where the scientific and social status of the medical graduate is more or less a matter of surmise, but it savours of impertinence to embody them in a form intended for use by registered practitioners in this country. It is to be hoped that medical men who happen to be called upon to fill in these forms will safeguard their personal and professional dignity by steadfastly refusing to use the form as at present edited.

Preliminary Professional Examination.

A SUBJECT which is sure to excite wide attention was adverted to by Mr. T. B. Saunders, secretary of the London University Commission, at the dinner of the Pharmaceutical Society last week, viz., the raising of the standard of the preliminary arts examination for chemists. Mr. Saunders struck the right note when he spoke of the implicit confidence reposed in chemists by the medical profession and how it was therefore a matter for congratulation that the new scheme for the preliminary arts examination

was to be introduced that year. As the speaker very truly observed, it showed that the Society were determined that the men they sent out into the world with the stamp of their approval should possess not only general, but special education as well, and that in point of culture, and in the character which culture ought to give, pharmaceutical chemists should be able to hold their own with men in allied walks of life. It is to be hoped that this advance in the education of students of pharmaceutical chemistry will strengthen the General Medical Council in resisting any attempt to weaken the stringency of the preliminary examination to the medical profession.

The Housing of the Poor.

THERE can be little doubt that Mr. Chaplin's proposals for the amendment of the Housing of the Working Classes Act, 1890, fail to touch the root of the question. The local authorities throughout the United Kingdom refuse to exercise existing powers and close insanitary houses because such a proceeding would simply turn into the street a number of folks who would have no other place to go to for shelter. Meanwhile the health of the community is being slowly but surely undermined by the gross overcrowding that exists in the slums not only of poor but also of rich districts in the Metropolis and other large towns. The toll demanded by King Death in these densely-populated backwaters of poverty is terrible, and often mounts up to twice and sometimes thrice the mortality of a wealthy quarter. Last week in the House of Commons some statistics were quoted showing the magnitude of the evil which is steadily sapping the health and the morality of our labouring classes. It was stated that in London there were thirty thousand people living at the rate of six in a room; nine thousand living at the rate of seven in a room, and three thousand at the rate of eight in one room. One result of this scant room has been a general advance of rent during the past few years from 20 to 50 per cent. or more. The fact of the matter is that the whole hinges upon landlordism. The cost of land, its burden of ground rent, and the extortionate house rents will have to be dealt with before the problem of the housing of the working classes can be satisfactorily settled. In this way the health reformer must first become a law reformer.

Posterior Basic Meningitis.

THE remarkable disease known under the name of posterior basic meningitis has been almost, if not quite unravelled by the researches of modern bacteriology. The retracted head, the staring eyes, the vomiting, the convulsions, and the champing of jaws and teeth render the clinical picture as a rule readily recognisable. The malady, first carefully described by Drs. Gee and Barlow in 1878, was pointed out by Dr. Carr in 1897 to resemble a specific disease. It has since been discovered that the immediate cause of the meningitis is a small aerobic diplococcus which can be readily cultivated at a temperature of

37 degs. C. The disease is thus infective in character, but in spite of that fact, and of its wide endemic distribution, there has so far been no evidence of its communicability from child to child. In this respect it closely resembles epidemic cerebro-spinal meningitis, with which it is closely allied if not identical. The difference appears to be that posterior basic meningitis is due to a specific bacillus, while epidemic cerebro-spinal meningitis may be the result of multiple infections. Posterior basic meningitis is a fatal disease, as the mortality reaches about 90 per cent. The outlook, however, is more hopeful than in tuberculous or suppurative meningitis, whether the latter condition is due to pneumococci or not. Unfortunately the better knowledge of the origin of the posterior basic meningitis has not hitherto led to any corresponding advance in treatment. The operation for draining the ventricles has not met with much success. However, there is little doubt that one day we shall find the exact *locale* of the infective organism as well as some means of combatting the specific diplococcus in the body of the patient.

The Queen's Visit to Netley.

WITH the tender solicitude which has characterised the attitude of Her Majesty during the present campaign another Royal visit to Netley has brought comfort and happiness to the hearts of the wounded and sick who are lying there, the tangible evidences of the arduous struggle which is being waged in South Africa. It is impossible to over-estimate the moral effect of Her Majesty's sympathy on the victims of the war, and many touching incidents are related as having taken place during the Royal progress through the crowded wards. It is hardly necessary to say that the visit was the occasion of exuberant enthusiasm both inside and outside the hospital, and our gratitude is due to the Royal lady who thus testifies to the affectionate interest which she takes in the welfare of those who have suffered in the cause of Crown and country.

Another Margate Circular.

THE medical profession of Margate appear to be marked out specially for the operations of the injudicious advertiser. Last week we drew attention to a broadcast circular in which the names of two well-known surgeons, one in London and the other in Margate, were prominently brought forward in connection with their professional work and opinions. This week we have been favoured with an hotel circular in dainty lilac cover, stamped with a gold armorial bearing, and having a pleasing effect of Bond Street stationery in its most aristocratic form. The first page of contents, however, revealed the truth by its superscription, "Tariff of charges of the Cliftonville Hotel, Margate." After a list of the price of bedrooms, the cost of hot or cold joints, vegetables, chops, and so on, the main part of this little brochure is devoted to "Extracts of Margate as a health resort." The name of the author and his qualifications are set forth fully as "H. Evelyn

Crook, M.D., B.S.Loud., F.R.C.S., Eng." That gentleman deserves our sympathy in the unpleasant position in which he has been placed by the indiscretion of the hotel proprietors, who cannot be expected to recognise the delicate shades of sentiment that sway the medical profession in matters that savour of self-advertisement. As the extract was doubtless inserted without any reference to Dr. Crooke's wishes, it is not unlikely he would have ground for legal action on the score of damage to professional status. The basis of such an action would possibly be found in an infringement of copyright.

Naked Eye Diagnosis.

IN these days of elaborate clinical investigation there is no small danger that the medical attendant may be inclined to undervalue the evidence available to the unaided senses of the observer. It is perfectly marvellous how the watchful eye of a skilful man can, by simple inspection, gain an insight into all kinds of peculiarity presented to him in the person of a patient. Such trained intelligence is feebly represented in the text-books by more or less elaborate efforts to describe diatheses and cachexiæ. When once the habit of carefully noting the outward and visible indications of acquired or inherited characteristics has been cultivated there will be no lack of material for its further ripening, for every fresh patient will furnish a fresh problem to be solved. The art of diagnosis consists essentially in the logical process of ascribing signs and symptoms to their proper cause. In the consulting room it is impossible to bring all the modern resources of the laboratory to bear upon a case seen for the first time, and the physician has then to depend to no small extent upon his naked eye diagnosis. Nowadays the student of medicine is so filled with minute knowledge of all kinds of abstruse studies, such as the bacteriology of the blood and of the urine, that he is apt to overlook the homely study of the patient himself apart from the microscope and the test tube and the other armamentaria of modern clinical research. With the advent of the first patient to his consulting-room, however, comes the lesson, often with a rude shock, that there is much wisdom wanted in the practice of medicine that is neither taught in the class room nor demanded of high standard examinations.

Importation of Small-Pox from Russia.

ON the whole it may perhaps fairly be claimed that the modern quarantine system adopted in the United Kingdom compares favourably with that of any other country both for sweet reasonableness and for practical efficiency. It is all the more surprising, therefore, to learn on the authority of the *Liverpool Journal of Commerce* that small-pox may be imported without let or hindrance into the heart of our population. The facts as related by the above mentioned journal are simple. An English engineer left Moscow on April 18th suffering from hæmorrhagic small-pox. The rash was out, and passing through

Warsaw, Berlin, he reached Flushing at midnight of April 19th. He touched English ground at Queenborough on April 20th, at 6 a.m., and reached London at 8 a.m.; Manchester, 3 p.m.; Staleybridge, 3.45 p.m., and was finally deposited in his own house at the last mentioned place at 4 p.m. on the 20th. After the fatigue and exposure of such a journey it is hardly surprising that the unfortunate patient died next morning. At least two cases of direct infection have since occurred, and it is left to conjecture how many were caused *en route*. The Medical Officer of Health, Dr. Roberts Dudley, may well marvel at the whole affair. "Why this man was not stopped at Queenborough," he writes, "or certainly London, I cannot make out, for he was so ill when he arrived in Manchester he had to be wheeled on a trolley from one platform to another, and again wheeled on a trolley when he arrived at Staleybridge, and yet no one seems to have imagined he was suffering from small-pox though the rash was well out." The Cheshire County Council, upon the strength of the foregoing history, have passed a resolution calling upon the Local Government Board to take effective measures for preventing the importation into England from foreign countries of persons suffering from small-pox or other infectious disease. The Liverpool journal calls the occurrence a "wicked evil," and there is no little justification for its strong language. Immediate action is imperative on the part of the Local Government Board.

Unsoundness of Mind or Lunacy?

SPEAKING at a meeting of medical men a few days ago, Dr. G. H. Savage made some very interesting references to the difficulty and difference of opinion concerning the correct definition of unsoundness of mind and insanity. The Lunacy Commissioners act on the idea that everybody of unsound mind is a lunatic, and this has led to the prosecution of medical practitioners for taking into their houses patients certainly unsound in mind, but whom leading alienists would decline to regard as lunatics. It is perfectly well known that there are large numbers of people of unsound mind and drunken, and it is equally clearly recognised that members of the medical profession had better leave them alone as far as the Lunacy Law is concerned, for if doctors are ill-acted enough to do otherwise they may eventually have grave reason to regret their action. Undoubtedly the most troublesome problem arises when a medical decision is sought in a case where a patient is slowly passing from mere unsoundness of mind into insanity as a natural development. Such people cannot be treated as lunatics, they can only be regarded as persons of unsound mind. The question is further complicated when defective memory has to be considered, and when, perhaps, to that is added the patient's vacillation in coming to any decision. Then the wide divergence between the law's definition and the medical man's opinion becomes most apparent, and few will be found to deny that lunacy legislation needs emendation.

Mr. Wootton and the Pharmaceutical Society.

MR. A. C. WOOTTON, late editor of the *Chemist and Druggist*, has been elected a member of Council of the Pharmaceutical Society. With something like thirty years' experience of the trade and its yearnings, Mr. Wootton cannot fail to be a useful acquisition to that body. He has, moreover, the not unmerited reputation of being able to state distinctly what he approves and what he objects to, and it is felt that a vigorous dissentient will find ample scope for activity in this sphere. We trust, however, that he will not allow the sentiments of hostility to the medical profession which characterised most of his utterances when he directed the *Chemist and Druggist* to vitiate the atmosphere of his new surroundings, not indeed that they would be ever likely to be productive of positive harm but rather that, by constant reiteration, the expression of such feelings tends to cloud the friendly relations which ought naturally to exist between practitioners and the followers of this ancillary calling.

Death from Jaundice.

IN commenting lately at Guy's Hospital on the way patients with jaundice usually die, Dr. Hale White mentioned that as a rule at examinations candidates are ignorant on the subject, the few that do know rattling off "coma, convulsions, and death." The weak part of that answer is that coma is much more frequent than convulsions. There is nothing more characteristic or striking in medicine than the death of a man who has been suffering from poisoning by bile. Day by day he lies in bed, becoming more and more comatose, more and more lifeless, his breathing is less, his pulse is less, and life disappears so slowly that often the medical attendant alone can tell when life is extinct. The coma is so deep that he cannot be roused, and to the ordinary observer the deeply greenish-yellow tinted and wasted patient appears already dead. Dr. Hall White, in concluding his remarks, said that it is important to remember that bile is a poison and that it is a poison the end of which is coma.

The Army Medical Service in France.

IT is not without interest to note that in France the same difficulty is experienced in recruiting medical officers as in this country. The dearth of volunteers has been accentuated by the creation of fresh services, and the Minister has found it necessary to raise the age of admission from 26 to 28. It remains to be seen whether this concession will have the desired effect. The probability is that it will not, seeing that the proportion of medical men to the population is smaller than here, and the conditions of service are more exacting and less remunerative. We do not hear of a similar difficulty in connection with the Army Medical Service in Germany, but in that country practice-less doctors exist in far greater abundance than in France, and, moreover the Government is enabled to adopt more

drastic measures than would be tolerated or approved in either France or England.

Camphorated Oil Frauds.

THERE has been a raid on retail chemists and other tradesmen all over the country in respect of the sale of *oleum camphoratum*, known *materia medica* as *linimentum camphoræ*, and quite a large number of them have been found guilty of selling as such products which failed to come up to the official standard either in respect of the proportion of camphor or by reason of the employment of an inferior hydro carbon as a vehicle. We have seen this form of commercial dishonesty described as a "cruel fraud," but in view of the nature of the application it is hardly to be supposed that the composition has any particular importance. For this reason one is disposed to regret that so much energy has been wasted on a therapeutically insignificant preparation when there are so many more important products the purity and strength whereof are matters of great moment.

Indian Medical Service Dinner.

WE are asked by the honorary secretary to announce that the annual dinner of the Indian Medical Service will take place at the Hotel Cecil on Thursday, June 14th, 1900, at 7.45 p.m., Sir Trevor Lawrence, Bart., in the chair. Officers intending to be present should communicate with the Honorary Secretary, Mr. P. J. Freyer, 46, Harley Street, London, W.

THE Bridgend Guardians find a difficulty in keeping their nursing staff at the Infirmary on a working footing owing to the unpopularity of that institution with the nursing sisterhood. We gather from the reports that it is not so much the place as the management that renders existence therein intolerable to the nurses, and a vague idea of the tyranny thereof may be formed from the question with which a resigning nurse terminated her letter: "Why are the nurses not allowed starch in their aprons?" A Local Government Board enquiry will be necessary to decide this momentous question, for, failing a satisfactory settlement, the sick poor of Bridgend may have to take up their beds and walk for want of proper attendance.

THE committee of the Liverpool School of Tropical Diseases have decided to despatch at an early date an important and well-equipped expedition to the Amazon to investigate yellow fever. This is the third expedition organised by the school within the last nine months at considerable expense. The expedition will probably, in the first instance, proceed to Baltimore to confer with the yellow fever experts at the John Hopkins University, afterwards going to Para and other places on the South American coast.

MR. JOHN CUBBIN, M.D., C.M., of Preesall-with-Hackinsall, was charged a few days ago at the Garstang Police-court, under Section 40, Sub-sec-

tion 2, of the Births and Deaths Registration Act, 1874, with issuing a false medical certificate, in that he was not "duly registered." The excuse was that non-registration was due to an oversight, but the Bench imposed the maximum penalty, £10, and costs or two months' imprisonment.

THE total number of cases of plague at Port Said to the end of last week was 31, with 15 deaths. Numerous dead rats and mice have been seen, and the sanitary authorities have issued a circular notifying this discovery, and requesting the inhabitants to assist in destroying such vermin and enjoining thorough disinfection.

PERSONAL.

DR. ARTHUR TUXFORD has been elected Coroner for the North Holland division of the county of Lincolnshire.

DR. F. W. TUNNICLIFFE has been appointed to the Chair of Materia Medica and Pharmacology at King's College.

SIR THOMAS SMITH, it is stated, will not seek re-election to the Council of the Royal College of Surgeons of England.

DR. C. H. PRESTON has been appointed lecturer on Dental Anatomy and Physiology at Owens College Manchester.

DR. PATRICK MANSON and Mr. Leonard Hill have been selected by the Council of the Royal Society for election as fellows.

DR. JAMES WALKER, Professor of Chemistry at University College, Dundee, is one of the newly elected Fellows of the Royal Society.

MR. WILLIAM HENRY POWER, F.R.S., has been nominated as a Crown member of the General Medical Council for the ensuing five years.

DR. FRANK G. CLEMON has been appointed British delegate to the Ottoman Board of Health and physician to the British Embassy, Constantinople.

THE Vice-President and Council of the Royal College of Surgeons, Ireland, will entertain the President at dinner on Saturday next, May 26th, at the Shelbourne Hotel, Dublin.

DR. THEODORE WILLIAMS will deliver the opening lecture of the summer session at the Brompton Hospital for Diseases of the Chest on the 23rd inst., taking for his subject "The Relation of Pleurisy to Pulmonary Tuberculosis."

MR. ALFRED DUKE, M.B., F.R.C.S.Ed., was presented last week with a solid silver tea service and tray, a purse of gold, and an album containing an illuminated address by the inhabitants of Whitley, Northumberland, in token of their esteem, on leaving the neighbourhood to practice elsewhere.

MR. JOHN H. MORGAN, who has been elected president of the Medical Society of London for the session, 1900-1, will be a candidate for one of the vacant seats

on the Council of the Royal College of Surgeons of England. Mr. Ward Cousins, of Southsea, has also been induced to come forward.

THE following gentlemen have been admitted to the Fellowship of the Royal College of Physicians of London:—Robert Bridges, M.B., F. F. Caiger, M.D., H. A. Caley, M.D., C. Dukes, M.D., H. M. Fletcher, M.D., L. G. Guthrie, M.D., C. M. Handfield-Jones, M.D., H. Head, M.D., A. Routh, M.D., S. Taylor, M.D., R. T. Williamson, M.D.

Literature.

BUBONIC PLAGUE. (a)

AT the request of the editors of the *Imparcial*, one of the best known and progressive of the Spanish political journals, Dr. Montenegro undertook the task of collecting, arranging, and investigating all the information that could throw light on the etiology and nature of the bubonic plague.

His work bore good fruit, being principally instrumental in stimulating the Spanish authorities to adopt preventive measures against the spread of the plague in the Peninsula. From time to time THE MEDICAL PRESS AND CIRCULAR reported the steps taken by the authorities and the character of the epidemic they had to contend with. We therefore take a great interest in Dr. Montenegro's excellent monograph, in which the reader has a well-told story of the plague, and the best account we yet have of its therapeutics. The book opens with a description of the Yersin's and Kitasato's bacillus, and an account of the conditions under which it lives and propagates. It is written with that mastery of the subject which years of labour in bacteriology in the splendidly-furnished Municipal Institution of Madrid gave the author.

The prodromata of the disease are next considered, and the development of the symptoms and their sequence as found from experiments on the lower animals, and close clinical observation on the human being clearly and tersely told. "Transmission of the plague" is an exhaustive account of the many channels by which the poison has been known to travel.

Prophylaxis, including a detailed statement of the sanitary measures necessary, is a very valuable addition to hygienic medicine, one which might be read with benefit by all interested in sanitation.

The clinical description is illustrated by typical cases of the different forms the disease assumes. Under treatment we get a *resumé* of all the therapeutic remedies, including serum inoculation and valuable hints on dietetics. The appendix brings the information up to the present, and is valuable as containing a chapter on sero-therapeutics, giving Bandi and Stigmitta's views on the subject.

Dr. Monro has produced a good translation of a book rich in information on one of our most dreadful epidemic diseases. It is a book valuable to the bacteriologist, the sanitarian, and the physician. It reflects credit on Spanish medicine, and its translation enriches English medical literature.

SQUIRE'S PHARMACOPEIA OF THE LONDON HOSPITALS. (b)

THE publication of this edition has been delayed by the necessity of waiting until the various hospitals had

(b) "Bubonic Plague: its Course and Symptoms and Means of Prevention and Treatment, according to the latest Scientific Discoveries; including Notes on Cases in Oporto. With an Appendix specially written by the Author for the English edition." By Dr. José Verdes Montenegro, ex-Interne of the Central University of Medicine, Associate Physician of the Hospital de la Princesa; and Professor at the Municipal Micrographical Laboratory, Madrid. Authorised Translation by H. Munro, M.D. London: Baillière, Tindall and Cox. 1900. Price 3s. 6d. net.

(a) "Pharmacopœia of the London Hospitals." By Peter Squire. Seventh Edition. London: J. and A. Churchill. 1900. Price 6s.

brought their respective pharmacopœias into line with the last issue of the "British Pharmacopœia." Since the last edition (1891) as many as twenty-one hospitals, we are told, have issued new editions, many of the formulæ having been altered and new preparations introduced.

This little work, which represents the crystallised wisdom and experience of many generations of prescribers, is invaluable to practitioners, whether general or consultants, especially now that prescribing tends to become a lost art. It enables the physician to formulate his requirements with pharmaceutical precision without running the risk of associating incompatibles, and it suggests combinations which experience has shown to be valuable. Habitual reference to this synopsis of formulæ will enlarge the practitioner's vocabulary of remedies just as methodical recourse to the dictionary extends and amplifies his knowledge of language, with advantage to himself and benefit to his patients. The work, in fact, represents a very successful attempt to generalise knowledge of a most useful and practical kind.

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

CONGENITAL LARYNGEAL OBSTRUCTION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Any confusion that may exist between congenital laryngeal obstruction and other forms of laryngeal stridor in infants is largely due to the terms stridor, spasm, and obstruction having been made interchangeable by authors describing one and the same disorder.

I thought I had guarded myself against any charge of error of this kind when I said that with respect to adenoids being responsible for laryngeal stridor and spasm I was not aware that any one had asserted them to be responsible for actual laryngeal "obstruction."

But I still think that "congenital laryngeal obstruction," the term preferred and adopted by Dr. Sutherland and Dr. Lambert Lack, is unfortunate for the condition they describe; since it is made synonymous with the already-accepted definitions of congenital aryngal stridor and infantile laryngeal spasm.

None of these terms, indeed, represents the actual lesion, which is one of congenital malformation—a very different thing from actual disease. In the fifth edition of my book, "The Throat and Nose, and their Diseases," p. 646, I have myself described it as a 'congenital vestibular stenosis,' which accurately defines not only the pathological nature of the narrowing, but also its situation in the larynx. I have pointed out in the same place that neither the physical appearances nor the respiratory symptoms are consistent "with the existence of an organised constriction" such as would be represented by a web, a cicatrix, a neoplasm or external pressure.

I am, Sir, yours truly,

LENNOX BROWNE.

15, Mansfield Street, May 17, 1900.

PROFESSIONAL SECRECY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Mr. Sers is no doubt right in affirming that "the medical profession . . . has no prerogative in refusing to give evidence beyond any ordinary witness," but he misses the point for which many of us are striving, viz., to establish that prerogative. Judging from the attitude of Her Majesty's judges in several recent cases they would hesitate to punish a medical witness who declined to violate the confidence reposed in him by his patient.

Exception might be made in criminal cases, but in civil courts such confidence ought to be regarded as inviolable. In the former case, it may fairly be urged that the interests of individuals must be subordinated to the interests of society at large, but where the ques-

tion at issue is merely the right of two conflicting parties, that contention would not hold good.

I am informed that Mr. Sers is in error in supposing that no "secrecy" exists between lawyers and their clients in the sense referred to.

I am, Sir, yours truly,

CONSCIENCE.

APOSTOLI'S TREATMENT OF FIBROIDS.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—If the results of the electrical treatment of uterine fibroids are as favourable as Mr. Skene Keith would have us believe, how is it that they have not been brought prominently to the front in one or other of the medical societies?

Mr. Keith will find it difficult to induce your readers to believe that gynaecologists are prejudiced against the treatment to such a degree that they systematically taboo the discussion of the method. The fact is, judging from what one reads in the journals and hears at the societies, that the evidence brought forward by the advocates of the treatment has not been such as to carry conviction. No one disputes that fibroids do sometimes become reduced in size as the result of the treatment, but this result seems to be by no means uniform, and is attended by the very tangible risk of setting up retrograde changes in the mass and of causing sloughing.

One would like to know where the "well-known teacher of obstetrics" obtained his information that the mortality after hysterectomy was 25 per cent. Even if this be correct the figures must comprise the results of hysterectomy for uterine cancer, a very different operation—in its results—to that for the removal of a fibroid-encumbered uterus.

The electrical treatment of fibroids is on its way to join the electrical treatment of urethral stricture in the limbo of discredited methods of treatment, and arguments more cogent and precise than those advanced by Mr. Keith will be required to rescue it from oblivion.

I am, Sir, yours truly,

GYNÆCOLOGIST.

THE TREATMENT OF ALOPECIA AREATA.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In the report of Dr. Tom Robinson's case of Alopecia Areata in the last number of the MEDICAL PRESS AND CIRCULAR, it is stated that the patient was ordered "to wash the scalp with spirits of soap every other day, and to cut the hair musicians' length." I write to ask what is the "spirit of soap," and what is "musicians' length." I have had a case of alopecia areata under treatment for some time, but that has defied all the ordinary remedies, and I shall be thankful for the information which I seek in the interest of my patient.

I am, Sir, yours truly,

PRACTITIONER.

THE DRAWBACKS OF PERSONAL NOMENCLATURE.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The writers of text-books little suspect the unnecessary confusion they inflict on their readers by the reckless use of surgeons' or makers' names to designate particular sorts of apparatus. This practice is bad enough when we are referred to Little's *this* or Hutchinson's *that*, though reference to the index will usually enable the harassed reader to discover what is meant. In surgical treatises, however, the myriad references to somebody's splint or bandage are positively bewildering, especially as very often no description is given of the apparatus, or, if so, is not referred to in the index.

I have just been reading Mr. Stonham's new work on Surgery, and in a single paragraph he mentions various splints under the names of Cline, Arnold, Dupuytren, Liston, and Roughton, not one of which is mentioned in the index. How then are we poor students to identify the particular appliance he wishes us to use? One way out of the difficulty would be to add a surgical instrument maker's illustrated catalogue as an appendix to the work, or the author might even condescend to

figure all apparatus referred to by him and give the reference in the index.

I am, Sir, yours truly,

A VEXED STUDENT.

A REMARKABLE CIRCULAR.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—My attention has been drawn to the note headed "A Remarkable Circular," on p. 510 of your issue of the 16th inst. It is not my object to discuss the tone or purpose of the remarks made. I merely desire to say that the "Circular" under reference was merely a letter, which certainly I had printed for convenience sake, but which was not intended for the public eye nor distributed broadcast in the way suggested, but merely sent to a few members of the profession, selected by myself from those connected with some of the chief hospitals in London. It is, I think, scarcely necessary for me to say that neither of the surgeons whose names were mentioned in my letter were even aware of my having written such a letter at all, and still less that their names had been mentioned in it. In so mentioning them I had not the slightest idea that I should be laying myself or them open to public attention of a disagreeable kind. My sole object in reciting the incidents which led to our starting a Home for delicate children in Margate was to emphasize, by describing the case of our own child, the apparent need for a Home such as it was our intention to open. The mention of the doctors' names was incidental and of course superfluous, and under the circumstances I much regret that they were mentioned; but I am constrained to add that the names were inserted in entire good faith on my part, and I confess it never occurred to me that the mere mention of the names of two eminent surgeons to a few of their brethren in the profession in a private communication would or could be construed into a breach of the unwritten laws of the medical profession.

I am, Sir, yours truly,

A. EVANS-GORDON, Lt.-Col.

Cliftonville, Margate, May 21st, 1900.

[It affords us much pleasure to give our correspondent the opportunity of publishing his explanation.—ED.]

Medical News.

Medical Society of London.

THE annual conversazione of this Society, which marks the close of the session, was given in their rooms in Chandos Street, W., on Monday evening. A reception by the President (Dr. Frederick Roberts) was followed by the oration, delivered by Dr. J. Kingston Fowler, F.R.C.P., on "Science and Medicine in the Eighteenth Century," of which we hope to publish an abstract next week. It was listened to with much interest by a very large audience, composed of Fellows and their friends. The company devoted the remainder of the evening to frivolity, varied by an excellent selection of music, admirably rendered by the Bijou Orchestra.

Association of Asylum Workers.

THE third annual meeting of the Association of Asylum Workers took place at the rooms of the Medical Society of London on Monday, May 14th, Sir J. Crichton-Browne in the chair, supported by Dr. Farquharson, M.P., and Sir John Batty Tuke, M.P. It is satisfactory to find that, according to the report, the membership of this useful association continues to increase, upwards of a thousand new members having been elected during the past year. The financial condition is so far satisfactory that no application for a grant from the fund has hitherto been refused. We may recall that the object of the association is to improve the status of asylum employés, and to afford them assistance when required. In an unostentatious manner much good work is being done, thanks to the active co-operation of persons interested in the care of the insane, and thanks especi-

ally to the untiring energy and devotion of the hon. secretary, Dr. Shuttleworth.

Lewisham Parliamentary Division of the Corporate and Medical Reform Association, Limited.

THE first annual meeting of the Lewisham and Sydenham Committees of this Association, to which all practitioners in the Parliamentary Borough of Lewisham were invited, was held on the 15th inst. at the Lewisham Infirmary, Dr. Toogood, chairman of the committees, presiding. The annual reports of the Association and committees were adopted. On the notices convening a general meeting it was unanimously resolved to constitute the Lewisham Parliamentary Division of the Corporate and Medical Reform Association, Limited; in order to indicate the intention to work for medical reform by political methods; and to follow for that purpose the appropriate and practical system of Parliamentary divisions and groups of divisions. The chairman, the honorary secretaries (Mr. F. S. Barnett, Lewisham, and Dr. F. Lorimer Hart, Sydenham), and the committees were elected, provisionally, officers and committee of the division, to frame rules, to submit to a general meeting. Members of Parliament had, it was remarked, stated that the only way to influence them is through their constituencies, and this way would be greatly facilitated by organisation on these lines. It was resolved that an address of thanks be presented to Mr. Penn, M.P. for the borough, inviting his co-operation in resisting registration of midwives, and that the political agents and chairmen be approached to arrange interviews and afford explanation of the objects of the division and association.

THE death is announced of Brigade-Surgeon-Lieutenant-Colonel William Center, as having taken place at Ealing on the 16th inst. This officer joined the Indian Medical Department in 1865, and from 1871 served in the Punjab as chemical examiner and professor in the Lahore Medical School. In 1882 he was appointed statistical officer in the sanitary department of the Government of India, and afterwards received the appointment of civil surgeon, Lahore, and superintendent of the lunatic asylum. From 1888 until his retirement in 1893 he occupied one of the professorships at Lahore Medical College.

By an Order in Council the prohibition, subsisting under her Majesty's Proclamation of January 11th, on the exportation out of the United Kingdom or the carrying coastwise of picric acid (trinitro-phenol), trinitro-cresol, carbolic acid (phenol), and cresylic acid (cresol) is withdrawn.

A PARTY of nurses and doctors, under the auspices of the Scottish Red Cross Hospital Society, left Glasgow for Southampton on Saturday last on their way to South Africa. The sections consisted of eight surgeons, 12 nursing sisters, 28 medical students (acting as first-class orderlies), and 33 second-class orderlies.

Royal College of Surgeons, Edinburgh.

The following candidates having passed the requisite examinations, were, at a meeting of the College held on 16th inst., elected ordinary Fellows:—

Alfred Campbell, M.B.C.S. Eng., L.R.C.P. Lond.; William Harry Hunter, M.B., C.M.; John Boyd Jamieson, M.B., C.M.; Joseph William Leech, M.B., Ch.B., M.D., and Charles Arthur Owen, M.B.C.S. Eng., L.R.C.P. Lond.

Society of Apothecaries of London.

The following candidates passed the subjects indicated during the May examinations:—

Surgery.—W. P. Allen, R. H. Birtwell, H. Greenwood, J. E. Howroyd (Section II.), C. Johnson (Section II.), J. Jones, J. H. Kellgren (Section I.).

Medicine.—W. Archer, A. St. J. Bateman (Section II.), R. H. Birtwell, B. Brookes (Section II.), T. Burdett, P. J. Fitzgerald, J. E. Howroyd (Section II.), F. S. Leech (Sections I. and II.), C. A. C. Salmon, C. V. Smith, S. Southam, T. E. Wilshaw (Section I.).

Forensic Medicine.—W. Archer, R. H. Birtwell, M. A. Curry, F. S. Leech, C. A. C. Salmon, C. V. Smith, S. Southam.

Midwifery.—R. H. Birtwell, M. A. Curry, E. de V. Dawson, P. J. Fitzgerald, W. P. A. Hardwicke, F. A. Hort, J. Hunter, R. A. Jones, J. H. Kellgren, S. Southam.

The diploma of the Society was granted to the following candidates, entitling them to practise Medicine, Surgery, and Midwifery:—W. P. Allen, R. H. Birtwell, B. Brookes, H. Greenwood, J. E. Howroyd, J. Jones, F. S. Leech, C. A. C. Salmon, and S. Southam.

Notices to Correspondents, Short Letters, &c.

✍ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a distinctive signature or initials, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

CAMBRIDGE APPOINTMENTS ASSOCIATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Will you kindly give publicity to the fact that we have upon our books a large number of those who are just completing their career at the university and who are anxious in the course of the summer to enter upon various departments of practical life as assistants, &c., both in England and abroad?

This association has met with so much sympathy during the short time it has been started that we feel confident that many, especially old Cambridge men, need only to be reminded of its existence to avail themselves of its aid if opportunity occurs.

I am, Sir, yours truly,

W. A. J. ARCHBOLD, Sec.

73, Trumpington Street, Cambridge, May 19th, 1900.

ERRATUM.—Dr. W. Sedgwick Saunders calls our attention to an error contained in our report of the Clinical Society's last meeting, at which he is stated to have presided. The vice-president, who occupied the chair, was Dr. Leonard W. Sedgwick.

ERASURE.—We fail to see what ground of complaint exists when a practitioner's name is removed from the *Register* as the result of his not having notified his change of address. This is the simplest and least expensive way of ensuring the accuracy of the list, and in the ordinary course of events is productive of no inconvenience or hardship.

DR. M. G.—The matter has been dealt with in the current issue. When you have read the correspondence we shall be pleased to publish any comment you may desire to offer.

MISS RAYMOND.—We are not aware that any material alteration has been made of late in the requirements in respect of materia medica, but if you will refer to the calendar of the University of London you can ascertain for yourself what they now are.

COUNTRY PRACTITIONER.—The subject of bicycle saddles was exhaustively dealt with at some length a few months since, and there is no present excuse for reverting thereto. The oscillating saddle you refer to is known as the "Esmond." It can be had, we suppose, of any large dealer in cycle accessories. We find that it was very favourably noticed by our cycling editor.

SENEX.—A lunatic is not so regarded by the law until he has been formally certified as such, and until this has been done he may presumably be treated like any other sick person. Under the circumstances, however, you would do well to insist on a power of attorney being given to a solicitor to represent the family and advise you as to the proper course to pursue. Should there be any opposition to the removal of the patient by third parties it would be necessary to move for a writ of *habeas corpus*; but this is a matter on which we are not competent to advise. If the patient be already certified as of unsound mind it would be necessary to obtain the permission of the Commissioners in Lunacy to his removal, and this is a point which should be cleared up without delay.

Meetings of the Societies and Lectures.

THURSDAY, MAY 24TH.

DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND (20 Hanover Square, W.).—4.30 p.m. Presidential Address by Dr. A. J. Harrison. Discussion on Seborrhoeic Conditions of the Skin, the Associated Constitutional Conditions and the Treatment (introduced by Mr. W. Anderson). Dr. R. Crocker, Dr. S. Mackenzie, and others will join in the discussion. Cases will be exhibited as usual.

FRIDAY, MAY 25TH.

CLINICAL SOCIETY OF LONDON (20 Hanover Square, W.).—8.30 p.m. —Annual General Meeting. Election of Officers, 1900–1901. Papers:—Mr. A. E. Barker: A Case of Gastro-enterostomy followed by Pylorotomy. Recovery.—Dr. W. F. V. Bonney (Introduced by Dr. Abercrombie): A Remarkable Case of Obscure Septicæmia treated by Antistreptococcus Serum and Nuclein.—Dr. W. Pasteur: Conclusion and Post-mortem Notes of a Case of Graves's Disease in which Bradycardia supervened (shown at the Society, April 25th, 1898).

Appointments.

BATTEN, F. E., M.D., M.R.C.P.Lond., Assistant Physician to the National Hospital for the Paralysed and Epileptic, Bloomsbury.
BURKE, P. J., M.B., B.S.Irel., Junior Resident Medical Officer for the Workhouse by the Chorlton Board of Guardians.
BUZEARD, THOMAS, M.D., F.R.C.P.Lond., Consulting Physician to the National Hospital for the Paralysed and Epileptic.
CHRISTIE, B. R. CRAIG, M.B., C.M.Édin., Resident House Surgeon to the Glasgow Royal Infirmary.
CLARKE, H. B., M.B., Ch.B.Vict., Junior House Surgeon to the Infirmary and Dispensary, Bolton.
DALLEY, W. C., M.R.C.S., Medical Officer for the Gyston Sanitary District of the Loughborough Union.
FERRIER, DAVID, M.D., F.R.C.P.Lond., F.R.S., Physician to the National Hospital for the Paralysed and Epileptic, Bloomsbury.
HARRIS, JOHN HENRY, M.R.C.S., L.S.A., D.P.H.Cantab., Medical Officer of Health for Dartmouth.
HAWTHORNE, C. O., M.D., M.R.C.P., Assistant Physician to the Royal Hospital for Children and Women, London.

HENNESSY, D., L.R.C.P., L.R.C.S.Édin., L.F.P.S.Glasg., Certifying Surgeon under the Factory Acts for the Bandon, Kiltrogan, and Brinny Electoral Divisions, County Cork.
HOYLE, F., M.B., Ch.B.Vict., Senior Resident Medical Officer for the Workhouse by the Chorlton Board of Guardians.
JACKSON, J. HUGHINGS, M.D., F.R.C.P., F.R.S., Consulting Physician to the National Hospital for the Paralysed and Epileptic.
KINSELLA, J. I., L.R.C.P., L.R.C.S., Certifying Surgeon under the Factory Acts for the Edenderry Poor Law Union, King's County.
ORMEROD, J. A., M.D., F.R.C.P.Lond., Physician to the National Hospital for the Paralysed and Epileptic, Bloomsbury.
OWEN, R., L.R.C.P., L.R.C.S.Édin., L.F.P.S.Glasg., Medical Officer for the Llandrog Sanitary District of the Carnarvon Union.
RUSSELL, J. RISIEN, M.D., F.R.C.P.Lond., Physician to the Out-patient Department of the National Hospital for the Paralysed and Epileptic.
TAYLOR, JAMES, M.D., F.R.C.P.Lond., Physician to the Out-patient Department of the National Hospital for the Paralysed and Epileptic.
TINDAL, ANDREW STEWART, M.D., Assistant Physician to the Victoria Infirmary, Glasgow.
TUNNICLIFFE, F. W., M.D.Lond., M.R.C.P., Professor of Materia Medica and Pharmacology in King's College, London.
TURNER, W. A., M.D., F.R.C.P.Lond., Assistant Physician to the National Hospital for the Paralysed and Epileptic, Bloomsbury.

Vacancies.

Birmingham City Hospital, Lodge Road.—Assistant Medical Officer Salary £120 per annum, with board, residence, &c.
Brecon Infirmary.—Resident House Surgeon, unmarried. Salary £90 per annum, with furnished apartments, board, attendance, fire, and gas. Apply to the Secretary, 6, Bulwark, Brecon.
Bristol Royal Hospital for Sick Women and Children.—House Surgeon. Salary £120 per annum, with rooms and attendance (not board).
City of Liverpool Infectious Diseases Hospitals.—Assistant Resident Medical Officer. Salary £100 per annum, with board, washing and lodging in the hospital. Applications to the Town Clerk, Liverpool.
County Asylum, Prestwich, Manchester.—Assistant Medical Officer, unmarried. Salary commencing at £125, increasing annually by £25 to £250, with board, apartments, washing, &c.
County Borough of Halifax.—Medical Officer of Health for the Borough. Salary £500 per annum. Drugs, medicines, and surgical appliances provided by the Corporation. Applications to the Town Clerk, Town Hall, Halifax.
Cumberland and Westmorland Asylum, Garlands, Carlisle.—Junior Assistant Medical Officer, unmarried. Salary £130 a year, rising to £150, with board, residence &c.
Devonshire Hospital, Buxton, Derbyshire.—House Surgeon and Assistant House Surgeon for twelve months. Salary of House Surgeon £100 per annum. Assistant House Surgeon £50, with furnished apartment, board, and washing in both cases.
Great Northern Central Hospital, Holloway Road, London.—House Physician for six months. Salary at the rate of £60 per annum, with board, lodging, and washing in the hospital. Also Junior House Physician for six months. Salary at the rate of £30 per annum, with board, lodging, and washing in the hospital. (See advt.)
Liverpool Dispensaries.—Head Surgeon. Salary £200 per annum. And four Assistant Surgeons, all unmarried. Salary £100 per annum each, with board and apartments in each case.
Middlesex Hospital Medical School.—Lecturer on Chemistry. Salary £150 per annum, with special fees and an allowance towards expenses of department.
Surrey County Asylum, Brookwood, near Woking.—Third Assistant Medical Officer, unmarried. Salary £120, rising £10 annually to £150, with board, lodging, attendance, and laundry.
Three Counties Asylum, Arlesey, near Hitchin.—Second Assistant Medical Officer (male), unmarried. Salary commencing at £150 per annum, with board, apartments, washing, and attendance. Applications to F. C. Butler, Clerk, St. Neots, Hunts.
Warneford Hospital, Leamington.—House Surgeon. Salary £100 per annum, with board, lodging, and washing.
Wiltshire.—Assistant (out-door) for extensive practice in Wiltshire. Salary £16 per month. (See advt.)

Births.

DOVE.—On May 15th, at Crouch Hill, London, N., the wife of Percy W. Dove, M.B.Lond., M.R.C.S., of a son.

Marriages.

BOND—LAWNE.—On May 12th, at Holy Trinity Church, Worcester, Charles Hubert Bond, M.D., D.Sc., the Heath Asylum, Baldwyn's Park, Bexley, to Janet Constance, the only daughter of Fred. R. Lawne, of Worcester.

Deaths.

ATKINSON.—On May 16th, at Swanton House, Ashford, Kent, Charles Stephen Abbott Atkinson, M.R.C.S., L.S.A., aged 58 years.
KEMPE.—On May 12th, at Lancaster Road, Bayswater, Charles Patrick Kempe, M.D., LL.D., M.R.C.S., L.M., L.S.A., aged 66.
PAYNE.—On May 13th, at Dryden House, Lincoln Road, Peterborough, George Speke Payne, M.R.C.S., aged 52.
PEARSE.—On May 20th, at Brierley Hill, Ed. Sainthill Pearse, M.R.C.S., L.R.C.P. (formerly of Bradninch, Devon), aged 70.
TRISTLE.—On May 7th, suddenly, at Inkerman Terrace, London, W., William G. Thistle, B.A.Oxon., M.R.C.S., L.R.C.P., aged 43.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXX.

WEDNESDAY, MAY 30, 1900.

No. 22.

Original Communications.

ON THE INDICATIONS FOR THE REMOVAL OF THE UTERINE APPENDAGES. (a)

By J. MACPHERSON LAWRIE, M.D.,

Physician to the Weymouth Sanatorium; Vice-President of the
British Gynaecological Society.

In the treatment of pathological conditions of the pelvic organs in women, the question of the removal of the uterine appendages is one which is often raised. The old headlong surgery of 20 years ago, when the ovaries and tubes were extirpated on the slightest provocation, has given place to a reaction in favour of extreme conservatism. I believe that the tendency has been a healthy one; indeed some such reaction was necessary in order to save gynaecology from a reproach which was fast becoming one of very great gravity. In some quarters the pendulum has swung to the far end of its excursion, as so often happens; and it has not yet quite settled down to small oscillations about its centre of rest. In this short paper I wish to offer a contribution to the question based upon my experience during the last four years. In this time I have removed the ovaries and tubes for various reasons in 43 cases; the full notes of all these have already been given in two papers read before the British Medical Association, in 1897 and 1899, and it will not therefore be necessary to trouble you with them here. I shall content myself with making such references to them as may be necessary for the elucidation of my subject.

I do not propose to consider here operations for the removal of ovarian or broad ligament cysts or solid growths; for these belong to a different category, in which there is no difference of opinion as to the indications for operation. For the purpose of discussion and to elicit opinions, I wish to tread upon debateable ground.

My subject, then, is the removal of the appendages for the following indications:—(1) Non-suppurative salpingitis; (2) chronic ovaritis; (3) small cystic ovaries; (4) pyosalpinx; (5) suppurating ovarian cysts; (6) uterine fibro-myoma; (7) tubal pregnancy.

The first three conditions are so often found associated that it will be convenient to consider them in one group, and the same remark applies to the fourth and fifth indications. This gives four groups of cases in which I have operated as follows:—

Cases.

- | | |
|--|----|
| A. For salpingitis, ovaritis, and cystic ovaries ... | 32 |
| B. For pyosalpinx and suppurating ovarian cysts ... | 6 |
| C. For uterine fibro-myoma ... | 3 |
| D. For tubal pregnancy ... | 2 |

Group A.—Removal of the Appendages for Sal-

pingitis, Ovaritis, and Cystic Ovaries, i.e., for Non-Suppurating Diseases of the Tubes and Ovaries.

The clinical picture of a case of this kind is somewhat as follows: The patient is usually about 30 to 35; the average age of my cases was 32·7, there being 9 under 30, 19 between 30 and 40, and four above 40. The majority of patients are married, the proportion among my cases being 19 married to 13 single. The great feature that all the cases have in common is pain of several years' duration; this takes the form of severe dysmenorrhœa, and of a gnawing, aching pain in the intermenstrual periods referred to the iliac regions, worse on standing, walking, or exertion of any kind. The patient's general condition is one of constant ill-health incapacitating her from attending to her employment or her household duties. She is nearly always pale and emaciated, and in fact she is a chronic invalid. A particularly distressing symptom is a profuse and constant leucorrhœa. If married, we find in addition that the patient suffers from dyspareunia, that she has been sterile for many years, or perhaps has never borne any children; in other cases two or three children have been borne in the early years of married life, and the patient dates her troubles from her last confinement. The quantity of the menstrual loss has no constant characters, in some cases it is excessive, in others it is scanty.

Now, what are we to do with these patients? We counsel much rest; we adopt palliative measures, hot douches, glycerine tampons, and so forth, with a view to reducing uterine and ovarian congestion; we prescribe purgatives, regulate the diet, and insist on a generally hygienic mode of life. Well, I am bound to say that in the majority of cases such improvement as there is can only be described as slight and temporary; I have made it an invariable rule to give palliative treatment a fair trial before advising radical measures, but the results have been, on the whole, disappointing. As a rule, the patient gets worse rather than better in the course of time; she is always disabled, always suffering; and if she was not hysterical to start with she is likely to become so; whilst the husband is likely to complain, not unnaturally, that his wife is "always in the doctor's hands." Under these circumstances, our duty seems to be clearly to remove the offending organ or organs, and restore the patient to health.

This is a matter on which authorities are not by any means agreed. If they were, there would, perhaps, be little need for me to bring the subject before you to-night. Some say, "These patients are hysterical, and no operation will cure them"; others consider that time is all that is necessary to effect a cure; some argue that the condition is not one that destroys life, and, therefore, no operation is warranted; lastly, it is urged that the ovaries and tubes in these cases are not unhealthy, and ought not, therefore, to be removed under any circumstances.

It is true that some of these patients are hysterical; but as I have said, the hysteria is often the effect and

(a) Read at Meeting of British Gynaecological Society, May 10th, 1900

not the cause of her sufferings; but whether hysterical or not, my experience is that an operation does bring about a cure, usually completely and permanently. Nor does my experience stand alone; it is that of many others. It will be sufficient for me to recall the recent paper by Mr. Furneaux Jordan, in which the satisfactory results of operations for the removal of the appendages are given.

With regard to the view that time will effect a cure, I may remark that in many of my cases time had had every chance of doing so, aided by palliative measures of all kinds, but without success. Supposing, however, that it were granted for the sake of argument, that two or three years of rest alternated with change of air and scene, together with hygienic measures, treatment at spas, sea-voyages, &c., would cure these patients, we should be still confronted with the question, In what proportion of cases can this costly and prolonged treatment be carried out? In but a small proportion, certainly, for many of these patients have to earn their living, and if not otherwise succoured, would starve before they were cured. Even with the wealthier classes, non-operation means usually postponement of operation; and if operation has to be resorted to, it may as well be done first as last, and all the intermediate suffering be dispensed with.

The argument that interference is not warranted because the condition is not one that threatens life is largely met by what has just been said. I may, however, remark further that in these days of safe operating many operations of expediency are permissible that would be contra-indicated if the risk were greater. It is only necessary to mention plastic operations for the cure of deformities, radical cure of hernia, operations for dysmenorrhœa, &c. Among my 43 cases there was one death only; and this one is to be attributed, not to the operation itself, but to the fact that she had not been operated on earlier, for she had got into a wretchedly poor condition, and in consequence did not rally from the operation.

Lastly, we have the argument that the ovaries and tubes in these cases are not diseased, or at least that they are not sufficiently diseased to require removal. I am convinced, from a careful examination of the organs after removal in my cases, that this view is erroneous. As a rule the ovaries were found to be enlarged and cystic, sometimes to a really considerable extent; the tubes often showed evidences of salpingitis, and in some cases were in the condition of hydrosalpinx. In another class of cases the ovaries were cirrhotic though not enlarged; and the careful work of Dr. Mary Dixon Jones, in America, has demonstrated that many of these ovaries are the seat of the conditions which she has described as endothelioma, gyroma and colloid degeneration. The almost constant sterility in these cases also shows that such ovaries are at least too far diseased to carry out their proper functions of healthy ovulation. We have yet to consider the question of conservative surgery in these cases. Much has been written on this subject of late years; indeed, we have had a communication from one of our own fellows, Mr. Christopher Martin. While granting at once that there is much to be said in favour of puncture and ignipuncture of small cysts, resection of ovaries and tubes, &c., it is also true that there is much to be said on the other side. Ovaries so preserved are fundamentally unhealthy, and the recorded cases in which such partial operations have been followed by pregnancy must be set off against the probably more numerous cases where a second operation has had to be performed later on. One of my cases is an instance of the disadvantage of incomplete operation, for it was one in which the abdomen had to be opened a second time, for the removal of an ovary and tube left behind at the first

operation, in the hope that the patient might be spared the necessity of double oöphorectomy. Moreover, these partial operations are not by any means always followed by relief of symptoms; and what these patients require above all, is not the preservation of this or that organ, but relief from their sufferings, and restoration to a condition of health and usefulness. This much they have the right to demand of us, and this we must give them.

Group B.—Removal of the Appendages for Pyosalpinx and Suppurating Ovarian Cysts.

Under this category all the patients recovered. There is no question in dealing with this class of case as to whether an operation should be done or not, for it is universally agreed that the diseased appendages must be dealt with surgically. This shows how rapidly opinions may change as to the indications for operation; it is only about seven years since Cullingworth read a paper at a sister society advocating abdominal section in cases of suppurative pelvic inflammation, and on that occasion considerable opposition was offered to his views by certain authorities in the obstetrical world. At the present time such opposition would be regarded as retrograde conservatism, and if it is still felt, it is not shown. The main question at issue to-day is as to the best method of attacking these conditions. Of late it has been strongly urged that collections of pus should be approached from the vaginal side; this course has been advocated quite recently at our meetings by such experienced operators as Mr. J. W. Taylor and Mr. Furneaux Jordan. I quite concur in the view that there are some cases in which the vaginal is the best route; notably those in which the appendages are bound down in the midst of a dense mass of adhesions, and there is a strong probability of coils of intestine being involved. If then fluctuation can be felt through the vaginal vault readily, or even fairly so, I think that the pus-sacs should be tapped vaginally. It is in such cases that the vaginal radical operation has been advocated, the uterus being first removed to make room for the removal of the appendages, and also for the reason that it is irremediably diseased and likely to act as a focus of further mischief. With this view I cannot agree; it seems to me better to simply tap and drain; and if the appendages have to be removed, it is better to do this operation through the abdomen. My reason for this is that in any case of suppurative disease of the appendages there are likely to be some adhesions which may or may not involve the intestine; and these can be dealt with much more safely and effectively with the fuller view obtained by abdominal section. In the class of cases which I have described above, as suitable for tapping through the vagina, the appendages are left, on account of the difficulty and risk which would attend any attempt to remove them; but in cases in which the fixation is not so marked, and in which no fluctuation can be detected vaginally, I should advocate the removal of the appendages by the abdominal route, for the reasons I have given, and also because they should not be left behind if this can be helped. The dangers of this course have been dwelt upon by various surgeons, the principal ones being the risks of wounds of the intestine followed by intestinal fistula, and the risk of fouling of the peritoneum by rupture of pus-sacs during the process of removal. Both dangers are, of course, real; but it is possible, in my opinion, to unduly magnify them. If due care be exercised in the separation of the adhesions, perforation of the intestine can usually be avoided, especially if this be done with the aid of sight, and if, when the adhesions are very firm, the separation be made from the inflammatory mass, rather than from the intestine itself. In the same way, the premature rupture of pus-sacs can usually

be avoided by enucleating them carefully; whilst even if rupture takes place, in spite of all precautions, no great harm necessarily results, because the pus is sterile in a large proportion of cases, and careful swabbing will usually avert the bad effects of even active pus. Let it, however, be understood that in saying this I am not advocating the slightest relaxation of care in endeavouring to enucleate these pus-sacs entire. On the contrary, no precaution can be too minute.

Group C.—Removal of the Appendages for Uterine Fibro-myoma.

Among my 43 cases of the removal of the appendages, there were three in which the operation was done for uterine myoma. In former years this proportion would probably have been larger, but at the present time hysterectomy has largely taken the place of oöphorectomy. In some quarters, indeed, oöphorectomy for myoma is relegated to the category of obsolete procedures, on the principle that the diseased organ should be removed and the healthy ones left. With this general principle I agree; there are, nevertheless, in my opinion, cases in which oöphorectomy is not only a permissible, but even the best operation. Such cases fall into two classes—first, cases in which the tumour is small and the appendages are unhealthy; secondly, cases in which the patient is in a very enfeebled condition through profuse hæmorrhage. The first indication was present in two of my patients; the uterus in both instances was only moderately enlarged, whilst the ovaries were enlarged and cystic. The latter required removal in any case; consequently, it seemed advisable to try to secure the diminution in size of the myoma by oöphorectomy, without submitting the patient to the graver risk of hysterectomy. The result has in each case fully justified the procedure, as both patients have been completely relieved of all their symptoms, and the tumour has been found diminished in size. Mr. Furneaux Jordan recorded similar good results in the paper which he read recently before the Society. The second indication—viz., profuse bleeding, leading to great prostration of the patient—led me to adopt the plan in my remaining case. In the paper I have referred to, Mr. Jordan points out that in these patients, whose recuperative powers are at the lowest ebb, hysterectomy might just turn the scale against the recovery of the patient; whilst if a second operation of hysterectomy is required later on, it can be done under much more favourable conditions, so that the fact of a second operation being required cannot be here advanced as a weighty argument against oöphorectomy. It is better to operate twice and save the patient than to lose her by a more brilliant first operation. There are, of course, cases of myoma in which oöphorectomy would be in any case unsuitable, or at least would have to be regarded as merely palliative; such are cases of very large tumours, of fibro-cystic myomata, and of tumours causing severe pressure symptoms. For these, hysterectomy is the only means of cure.

Group D.—Removal of the Appendages for Tubal Pregnancy.

This is included here for the sake of completeness, not because there is any divergence of opinion on the matter. Two of my cases were operations for ectopic gestation, and both recovered. It is not usually necessary to remove the appendages of both sides, unless obviously diseased, for there is no predisposition to recurrence of this accident, and on the other hand, the patient may subsequently become normally pregnant, and we should not without special reason, prevent this possibility.

I do not propose to enter here on the question of neurosis as an indication for oöphorectomy, for the simple reason that I do not consider it to be such. It

is the practically unanimous experience of a large body of operators in former years that the operation is not only ineffectual for the cure of neurosis, but actually harmful. I take it to be a matter of general agreement that it is in this department that abuses have existed which have tended to bring discredit upon the operation.

In conclusion, I may sum up the views expressed in this paper by saying that I believe that the ovaries and tubes require to be removed in the following conditions:—Chronic ovaritis, salpingitis and cystic disease of the ovaries, when palliative methods have failed to afford relief; suppurative diseases of the ovaries and tubes, *i.e.*, pyosalpinx, tubo-ovarian and ovarian abscess; fibro-myoma of the uterus of moderate size, either when the ovaries are diseased, or when the patient has been so debilitated by prolonged hæmorrhage that hysterectomy would be specially risky; and in cases of tubal pregnancy. Mere neurosis, apart from organic disease is not to be regarded as an indication for oöphorectomy under any circumstances. Further, I believe, that mere puncture and resection of the ovaries and tubes is in most cases inefficient and unsatisfactory, and that for pyosalpinx, the abdominal is usually preferable to the vaginal route.

PELVIC PAIN FROM IMPACTED URETERAL CALCULI. (a)

By SEPTIMUS SUNDERLAND, M.D.,

Physician to the Royal Hospital for Women and Children; Physician to the Royal Maternity Charity of London; Hon. Sec. British Balneological and Climatological Society.

Prefatory Remarks.—It appears to be the custom in most medical societies for the members to bring forward reports of their successes; but I venture to think that if a proper proportion of their failures with the history of the cases were recorded, that an equal measure of useful information would be supplied which would be the means of warning others, of helping them to avoid similar pitfalls, and of indirectly conducing to the welfare of mankind.

As the intricacies of the female pelvic organs, when in an abnormal condition, are only equalled by the intricacies of the female mind in its normal condition, it is not difficult to appreciate the fact that at times—and possibly frequently—pain in the pelvic region in women may be diagnosed as proceeding from some abnormality, disorder or disease of the uterus, ovaries or Fallopian tubes, which does not exist.

One object of the short paper I am reading to-night is to emphasize the fact that mistakes are made in dealing with the generative organs, and speculative or other treatment resorted to, under the belief that the uterus and ovaries are at fault, when the after history proves that they are blameless. It is certain that errors in diagnosis and treatment must sometimes be made by specialists as well as by medical men who treat disease of every portion of the body, and these remarks are offered in defence of myself and colleagues in the specialty which I practise, as well as on behalf of men engaged in general practice, because both consultants and general practitioners are implicated in having made wrong diagnoses in the following cases.

CASE I.—The first case dates back to 1886, when I was Resident Medical Officer in a hospital for women Mrs. R., æt. 29, was admitted complaining of pain

(a) A paper read before the West Kent Medico-Chirurgical Society, February 2nd, 1900.

in the left ovarian region of several months' duration. There was no history of any sudden onset of the pain, which was described as being of a cutting character and almost continuous, and was located to the left of the uterus. The patient was healthy-looking and did not show in her facial expression any marked evidence of wearing pain. On examination per vaginam the left ovary was felt prolapsed and tender, and after a few weeks' rest in bed with treatment, during which time the pain did not improve, the left ovary was removed by the surgeon in charge after a consultation. I well remember, when making my round of the wards that same evening, the wail of that woman when she cried out: "Oh, doctor, the pain! the pain! Just the same; no better!" Well, the pain never did improve while she was in hospital, and she returned home without relief. Three months afterwards she came to see me, and brought with her a small calculus as big as a small pea, which she had passed into a vessel while voiding urine a few days previously. Immediately afterwards the pain disappeared.

CASE II.—I saw Mrs. R., *æt.* 30, a flabby and indolent woman, the mother of three children, in 1891, on account of severe pain on the left side of the pelvis, which was located to the left of the uterus at about the junction of the body with the cervix, and radiated down the vagina and rectum. She had suffered the pain at intervals for about a year, and stated that it was always worse after excitement or worry. Sometimes it was accompanied by vomiting. Poultices, hot injections into the rectum and vagina had failed to relieve it. I never saw her in an acute attack of pain. She had been told by a medical practitioner that it was due to congestion of ovary and uterus and he had treated for this. In this case I diagnosed stone in the ureter and placed her under the care of my friend, Dr. William Travers, in the Chelsea Hospital for Women, where she remained a month. Dr. Travers agreed with my diagnosis. During her stay there she often complained of pain, but it was apparently not severe. The uterus was bulky, but otherwise normal, as well as the ovaries. There was no blood in the urine. She received instructions about diet, and I did not see her again till April, 1892, when she came to me stating that for a whole year she had been under the care of a gynaecologist who had considered her trouble due to uterine and ovarian disorder and had tried remedies and local treatment. She also stated that she had had a bad attack of pain about Christmas, 1892, and then during the next few months the pain had been persistent but not severe. In March, 1893, she was passing urine in the morning, felt slight pain in the urethra, and heard something click in the vessel; she found this was a small stone as large as a pea which she brought to me. After this she had no pain in the left side, but came to consult me in February, 1894, for similar pain which had appeared on several occasions in the same situation on the opposite side (the right) during the previous three or four months. I saw her two or three times at intervals during the succeeding few years, but the pain subsided; she never saw another stone. I have lost sight of her during the last few years.

CASE III.—I am indebted to Dr. Leonard Williams for the notes of this case, having been asked to see the patient in consultation with him to decide whether the ovaries and uterus were at fault, and I think I cannot do better than read his notes which are somewhat humorously written, and do not spare himself, myself, nor the previous practitioner under whose care the patient had been.

"I had known Mrs. H. for several years as a "creaking door" always ailing, but seldom definitely ill. She was happy in her home life, had had two children at an interval of ten years, and no mishaps.

She came of a family of pronounced neurotics. Her three sisters all "enjoyed bad health." One of them spent her time on the doorsteps of various London specialists, and her husband's money in their consulting rooms. Another suffered from intractable and exhausting hay fever from the day that her husband's holidays commenced until the morning he returned to his office, when it fled, to return no more for another year. The third they all agreed in condemning as "so very hysterical." Each member of the family had the tremulous voice, the ill knit figure, the depressed angles of the mouth, and the air of sweet resignation which so surely bespeaks the incorrigible neurotic.

Mrs. H., herself, had frequently sought my advice for obscure pains of an apparently rheumatic or neuralgic origin, which had generally yielded to simple treatment. On February 3rd, 1898, she consulted me for very severe pain referred to the region of the right ovary, the evidences of which had been sufficient to alarm a husband who had been rendered brutally callous by the shrill and frequent cries of "wolf" extending over a long period of wedded bliss. The present attack had come on quite suddenly when the two were out driving together in a dog-cart. They had traversed some unusually rough roads at a smart pace, for they were hurried, when suddenly the wife was taken with a sharp stabbing pain in the right side which caused her to cry out. Immediately after she felt very faint and inclined to vomit. Every movement of the trap increased the trouble, and the journey home was accomplished with great difficulty.

The local practitioner having diagnosed prolapsed and congested ovary proceeded to treat the condition with a vigour commensurate with its severity. Poultices, blisters, belladonna plasters and vaginal douches, vied with drastic cathartics for the honour of relieving the congestion and replacing the dislocated organ. Under the influence of these ministrations the patient became so alarmingly debilitated that her husband brought her up to town to see me. I examined her very carefully and could find no evidence whatever of the condition from which she was supposed to be suffering. There was certainly some tenderness on the right side when the examining finger was pressed upwards, outwards, and to the right, but as this did not seem to be elicited when the patient's attention was distracted, the cause of the condition was not clear. The patient nevertheless showed undoubted signs of having suffered, and the testimony of the husband on this point was very emphatic. I therefore asked my friend, Dr. Septimus Sunderland, to see the case, lest I should have overlooked some factor which could throw light on the matter. This he did, and although he made a very careful examination, its results were negative. We therefore decided that she should be isolated from the sympathetic influence of her friends, and under the observation of a nurse. This treatment was set in motion at once. She was kept in bed, given a great deal of milk and such like, massaged every day, and put upon arsenic and nux vomica. At the end of a fortnight she had visibly improved, and was allowed to lie on the sofa in another room. She continued to complain of the same "ovarian" pain on movement, but admitted that she was quite free from it as long as she was at rest. Her general health continued to show decided improvement. She gained flesh and colour, and lost her apathetic whining. On March 7th the nurse sent word to say that the patient had had a bad night, and was evidently in a great deal of pain. When I saw her she was lying on her back with her right leg drawn up, the face was contracted and the skin moist, the pulse was small and rapid. Very acute pain was complained of in the lumbar region on the

right side, passing into the groin and bladder, and giving rise to a desire to vomit. I gave a hypodermic injection of morphia and atropine, and directed hot flannels to be applied to the lumbar region. This had to be repeated two or three times in the course of the next few days, at the end of which the symptoms suddenly subsided. When the patient was again able to move about it was discovered the pain had completely disappeared. She left for home at the end of March, and remained perfectly well until the end of September, when the 'ovarian' pain returned. This was soon followed by another similar acute attack, since which time she has remained, for her, in good health."

In this case until the acute attack witnessed by Dr. Leonard Williams three medical men failed to diagnose the cause of the pain, for there is little doubt that renal or ureteral calculus was the cause. It is true that neither Dr. Leonard Williams nor myself had had the opportunity at the date of our consultation in February, 1898, of seeing the patient suffering from the typical symptoms of the passage of a renal calculus, which appeared later while she was under Dr. Leonard Williams's treatment. I myself was afterwards astonished that I had not suggested stone in the ureter as a possible cause, for the reason that the two first cases I have related had made a great impression on my mind, and when pelvic pain in women cannot be explained satisfactorily, I usually consider the possibility of a ureteral calculus being present, and believe I have diagnosed a fair number correctly.

In this case I was called on to decide if the uterus or ovaries were at fault, and finding no trace of illness in them, the "neurotic bogey" apparently effaced every other consideration from the thoughts of Dr. Leonard Williams and myself until the acute symptoms of the passage of a renal calculus—with pain in the lumbar region—made the diagnosis clear.

Possibly the reputation Dr. Leonard Williams enjoys in the department of neurology also influenced to a certain extent my views of the case. The patient certainly improved greatly in general health as the result of the treatment adopted.

On reading through Dr. Leonard Williams's notes one feels surprised one did not pay more attention to the sudden onset of pain in the first instance; we had no written notes on that occasion. This brings to my mind the importance when seeing cases in consultation of securing, if possible, written notes of the history of each case such as one never fails to obtain in hospital.

There are other cases I could give of pelvic pain in women where the diagnosis was difficult and uncertain, that I have myself diagnosed as caused by ureteral calculus, and in which the pain has disappeared after treatment, although no distinct visible proof of the diagnosis has been forthcoming. We must remember that tiny calculi may be too small to be felt per vaginam, may be passed without being noticed, and may come away when the patient is at stool.

Remarks on the above cases.—It is not surprising when one considers the intimate relations of the ureter in its lower part with the ovary, uterus, and upper part of the vagina, that pain caused by a calculus which has become fixed in the lower part of the ureter should be mistaken for ovarian or uterine pain. We must also bear in mind that pain in renal calculus may give rise to reflex or transferred pains, and that ovarian pain may thus be sometimes accounted for, as possibly in Case III.

Assuming in such cases as those I have related that one can exclude other diseases, and has an idea that a woman is suffering from a ureteral calculus, the question arises, what means are there at our command to attempt to elucidate this condition?

(1) It would be wise to take an X-ray photograph of the kidney to discover if stones be present there, in which case the diagnosis would be probably correct; ureteral calculus might co-exist with stone in the kidney.

(2) Palpate the abdominal parietes. Very rarely one might feel a calculus at the brim of the pelvis by this method.

(3) Inspect the orifices of the ureter in the bladder with the cystoscope. Occasionally, a stone may be seen projecting from the orifice of the ureter into the bladder. In such cases bladder symptoms are present, and the trouble may have been diagnosed as vesical calculus.

(4) Palpate the ureters.

I cannot do better than quote from the writings of Howard Kelly, of Baltimore, who has done so much in recent years to encourage the examination and exploration of the ureters in order to facilitate diagnosis in kidney diseases. He says:—"The ureter can be palpated through the anterior vaginal wall, from its terminus in the bladder up to the point where it passes beneath the broad ligament. It can be rolled in the loose cellular tissue under the index finger or often better bimanually, or in advanced pregnancy on the head of the child like a narrow tape or flattened cord without hardness. It must not be mistaken in this position for the obturator artery or nerve, or the upper border of the levator ani, or fibres of the obturator muscle, or the rim of the foramen. A diseased ureter becomes nodular and thickened, and is peculiarly prone to be mistaken for a cellulitis or an adherent ovary. I have demonstrated this fact on numerous occasions for a number of years. A large percentage of cases under treatment to-day for cystitis and for irritable bladder are in reality tender thickened ureters, and an intelligent palpation will detect the tube now hard and cord-like, bringing out the characteristic complaint of intense desire to urinate. An enlarged ureter can be easily further palpated per rectum behind the broad ligament and followed from there up over the posterior pelvic wall."

(5) Sound the ureters through the bladder.

I need not do more than refer to the methods devised by Howard Kelly of sounding or catheterising the ureters through the bladder, by which means impacted stone in the ureter may be diagnosed.

Thus one sees that stone in the pelvic part of the ureter might be detected by bimanual, vaginal and rectal examination, and by sounding the ureters.

Operative Treatment.—If the stone project into the bladder from the orifice of the ureter it must be removed through the bladder.

Mr. Hurry Fenwick teaches that a stone lodged in the lower part of the ureter within the last two inches will sometimes set up symptoms precisely like those of stone in the bladder, that is to say, bladder irritation and spasm.

If the stone can be detected by bimanual vaginal examination in the lower three inches of the ureter, but does not project into the bladder, it can be safely extracted by incising the roof of the vagina in the female.

If the stone be located at or about the pelvic brim, Mr. Hurry Fenwick recommends the abdominal incision used for ligature of the common iliac artery. The peritoneum having been raised, the lower end of the ureter is reached extra-peritoneally.

(For stone in the upper third of the ureter, the ordinary lumbar renal incision is indicated.)

Treatment other than Operative.—In the more acute attacks of pain a morphia and atropine suppository and rectal injection of hot water might be used. Frequent hot baths would prove of service, together with the ingestion of hot drinks and the application of hot poultices or bran-bags covered

with mackintosh. Inversion of the patient is said to give relief.

In the prolonged wearing cases of pelvic pain where ureteral stone is suspected some simple weak alkaline water containing few salts, such as Malvern, Contrexéville, Wildungen, or Kronenquelle, taken in the early morning fasting, and spread over a period of two hours may be recommended; or plain boiled hot water may be used in a similar way.

Piperazine given daily in doses of 15 grains is thought by some to be of service as a solvent of uric-acid stones, but the evidence of this is not satisfactory.

Errors of diet should be corrected and a proper dietary prescribed.

With regard to exercise, Mr. Hurry Fenwick recommends bicycling, riding, dancing, walking, in fact any exercise which would tend to dislodge the stone and encourage it to travel towards the bladder, assuming the pain be not increased.

Treatment at Health Resorts.—In such chronic cases as I have described, spa-treatment and climatic treatment seem to offer special advantages.

For it is necessary to maintain the general health and condition of such patients at as high a standard as possible, in order to enable them to bear the wearing pain. A health resort of suitable climate and surroundings is not difficult to select for any individual case.

At such a resort patients, when placed under a medical man for a definite period, will often take kindly to the diet suitable for their case, and carry out instructions which they will not do at home.

A course of hot baths at a spa, whether the natural waters be cold or thermal, could easily be arranged, and massage employed, for most of the spas have now special bath-houses, with attendant rubbers.

Of foreign spas I may mention Contrexéville and Wildungen, whose waters I have already alluded to; but our own native land offers also a number of spas of varying climates and attractions, one or other of which might be chosen to suit the individual patient, according to her necessities and ideas. And in these days of international complications we may be compelled to make more use of them for many diseases than has been the custom hitherto.

A selection could be made from Bath, Buxton, Leamington, Cheltenham, Tunbridge Wells, Matlock, Harrogate, Woodhall, Droitwich and Nantwich, in England; Llandrindod Wells, Llanwrtyd Wells, and Llangammarch Wells in Wales; Strathpeffer and Bridge of Allan in Scotland.

I am not advocating the ingestion of the waters at all of these British spas, and for this reason, that some of the waters would be too heavy for stone and kidney cases. But the patients would gain the other advantages I have alluded to, and could take the requisite quantity of bottled Contrexéville, Wildungen, or Malvern waters in the early morning, or even plain boiled water; after all, it is simple fluid which is the great requisite as far as waters are concerned, but it must be taken at the proper time, and preferably hot.

For particulars of the British Spas I suggest reference should be made to the useful book published by the Royal Medical and Chirurgical Society, entitled "Climates and Baths of Great Britain."

Of inland resorts other than spas, where from early spring to late autumn a bracing air and lovely rural surroundings can be found, I may mention Cronborough Beacon, in Sussex, at an altitude of about 800 feet, Hindhead and Grayshot in Surrey at a similar altitude, Bushey in Hertfordshire, Malvern, Ben Rhydding, &c. The health resorts on the seashore of the British Isles offer throughout the whole year an almost unlimited choice of places for those patients who do not find recreation and pleasure at

inland resorts unless seashore residence be contra-indicated for other reasons. In some of the larger of these a course of hot baths can also be arranged for. Sidmouth, especially, may be mentioned, as possessing an excellent bathing establishment, with all modern appliances.

In selecting a place, the time of year, the climate and surroundings, the local amusements, the idiosyncrasies of the patient, the capabilities of the local medical man under whose care the patient will be placed, must all be carefully considered. The wild and indiscriminate recommendation of health resorts about which one knows little must be avoided, and care taken that the patient shall be placed under the best possible conditions for the amelioration of her disordered state.

Conclusion.—I think the three cases will provide ample food for thought among the members of this Society present to-night, and I shall not be surprised if there are some here—especially amongst the senior members—who can give us somewhat similar experiences.

Possibly, medical men with large general practices have more opportunities of seeing and diagnosing such cases than myself, whose patients have usually some definite gynaecological trouble, and my experience may be stale to them. But I believe that to the junior members of the profession the narration of these cases should prove to be a warning and a guide.

In conclusion, I will assert my belief that a goodly number of women suffer from persistent pelvic pain of varying severity caused by a stone in one or other ureter, and that the pain is frequently considered by the medical attendant to be due to ovarian or uterine trouble or regarded as neuralgia or a neurosis or of hysterical origin. Occasionally, if the pain be situated on the right side, the appendix may be wrongly considered to be the source of the trouble, and this structure has been removed unnecessarily when the cause of the pain was really a ureteral calculus. Thus one sees that even general surgeons may make mistakes as well as general physicians, gynaecologists, neurologists, and general practitioners.

I would suggest that since patients suffering from chronic complaints congregate in hundreds of thousands at health resorts, the physicians practising at such places should bear in mind the possibility of a ureteral or renal calculus being the source of trouble in those cases of persistent pelvic pain in which the exact cause has not been discovered.

Therapeutic Notes.

By GEORGE FOY, M.D., F.R.C.S.

CHLORETONE (C₄ H₇ O Cl₃).

CHLORETONE, a new product, produced by the action of acetone and an alkali on chloroform, was introduced to the medical profession last autumn by Houghton and Aldrich, as a non-toxic anæsthetic, hypnotic, and antiseptic. It is a beautiful white crystalline compound, resembling camphor in appearance, smell, and taste. The substance is sparingly soluble in cold water, very soluble in strong alcohol, ether, chloroform, and benzine, and perfectly stable in the presence of dilute acids and alkalis. Administered by the mouth chloretone causes all degrees of anæsthesia, dependent on the amount given. Unlike other hypnotics, however, it does not depress the centres of the medulla, its principal action being on the cortical cells of the brain. Spectroscopic examination of the blood fails to reveal any effect upon the hæmoglobin, even after very large doses have been employed. During profound anæsthesia from chloretone the blood pressure

remains unaffected, as shown by sphygmographic tracings from the carotid artery; in some cases it has been found somewhat higher at the end than in the beginning of the experiments.

Dr. Dewar (*Ther. Gaz.*) writes: "Further investigations have developed the fact that chloretone has also an anæsthetic effect upon the peripheral sensory filaments, independent of its very pronounced influence on the central nervous system. This local anæsthetic action has been so thoroughly determined to be positive and constant that there is no doubt that we have in chloretone a safe and trustworthy local anæsthetic. Already it has begun to supplant cocaine in dental practice, since Houghton and Aldrich have shown that small amounts of chloretone, introduced subcutaneously to produce insensibility to pain in surgical work, are entirely harmless.

Chloretone, owing to its antiseptic and anæsthetic properties, is a valuable dressing for painful, lacerated wounds or burns. From experience acquired in his own practice, Dr. Dewar highly recommends it.

When introducing it Houghton and Aldrich stated (Iowa Am. Med. Ass.):—"Laboratory experiments quite conclusively show that it renders the mucous membrane of the alimentary canal insensible to irritants. As an hypnotic, chloretone is frequently efficacious in various conditions. Especially good results have been obtained from the exhibition of the drug in persistent insomnia in the aged, also in cardiac disease with renal complications accompanied by high arterial tension. In many instances where morphine, chloral, trional, and so forth, have been unsatisfactory, chloretone has been successful. Morphine, as is well known, increases the excitability of the nervous system when administered in large doses, and is frequently objectionable on that account. Chloral is irritating to the stomach, and depresses the heart. Chloretone does not possess any of these disadvantages, being only rarely followed by disagreeable after effects, though occasionally when large hypnotic doses have been given, drowsiness occurs on the following day."

Dr. Dewar has used the drug in six cases, of which the following is a summary:—1. A lacerated wound of the arm requiring thirty stitches. The wound was bathed in an aqueous solution of chloretone, and crystals of the chemical were sprinkled on the torn surfaces, it was covered with a dressing of chloretone gauze and a splint was applied. The patient declared that the passing of the needles gave him no pain whatever. During the period of treatment the patient never complained of pain, nor was the least sign of sloughing or inflammation observed.

2. A scalp wound which had been dressed with carbolic acid, and the following day the patient's temperature was 103° F. There was alarming oedema of the scalp, involving the frontal, left temporal, and both parietal regions. The sutures were removed, giving exit to a large quantity of sero-purulent fluid from the wound, which was then packed with chloretone crystals and covered with chloretone gauze. In three days all evidence of suppuration disappeared, and from that time the patient rapidly recovered. The next three cases were amputations of the fingers, in each of which chloretone was used, both as an anæsthetic and antiseptic, with the best results.

The last case was one of stricture of the urethra, through which it was impossible to pass a sound larger than a No. 10, French measurement. After injecting a solution of chloretone the patient permitted me to pass successively No. 12, 14, and 16 sounds, thoroughly dilating the stricture without causing pain or producing any undesirable after-effects.

Clinical Records.

THE CANCER HOSPITAL.

Two Cases of Recto-Vaginal Excision for High Rectal Cancer. (a)

By HERBERT SNOW, M.D. (Lond.), &c.,
Senior Acting Surgeon to the Cancer Hospital.

CASE I.—Annie C., æt. 57, widow, three children, was admitted into the Cancer Hospital on September 26th, 1899. She was a well-nourished, physically strong woman, suffering very intense continuous pain in the rectal region. The symptoms were described as of about a year's duration. Apparently the disease had existed for from two to three years. There was the usual history of antecedent trouble and worry; none of injury, or of "cancer in the family." I was informed by the relatives that the private medical attendant had pronounced the case beyond the scope of an operation.

The whole of the bowel was infiltrated as far as the finger could reach; but the upper margin could be felt, especially *per vaginam*, and the mass was mobile, easily pulled down. There was a sanious discharge from both vagina and rectum. The infiltration was hard and brawny—a very important point in such cases, in view of both prognosis and of surgical treatment.

On September 29th the whole growth with the recto-vaginal septum was removed; the latter as high as the posterior fornix. Douglas' pouch was opened, and was subsequently sutured with catgut. The rectal mucous membrane was finally sutured to the skin posteriorly; a large gaping wound in front being plugged with iodoform gauze, and a self-retaining catheter left in.

The patient made an uninterrupted recovery, and was then fitted with a vulcanite plug. She left the hospital in the best of health on January 27th of this year, to all appearance permanently cured, and has remained well to the present time. I am indebted to Dr. T. Johnston English for the photograph exhibited, which shows the condition after cicatrization. The os uteri forms the apex of a deep triangular *cul-de-sac* The end of the intestine is invisible.

CASE II.—Jane G., æt. 57, single, children's nurse, admitted February 16, 1900. A spare woman with very worn-out look, no injury. Said: "Much worry with troublesome children." No family history of cancer. The disease had existed two or three years, though the stated duration was only eleven months. Here again the patient had been told—this time at a women's hospital—that it was too far gone for operation.

There was a hard woody infiltration involving all but a very narrow strip of mucous membrane. The upper limit could not be reached *per rectum*, but could by the vagina. The whole seemed very mobile, and could easily be dragged down. There was sanious discharge from both canals, and after admission an attack of vaginal hæmorrhage from ulceration just within the vulva.

On February 23rd the diseased mass was excised, with the infiltrated recto-vaginal septum to within one-eighth inch of the uterus, the *labia minora* and the lateral walls of the vagina. Although previously so mobile, it was found that there was a small strip of infiltrated tissue stretching up beyond the apparent upper margin to the left broad ligament. This was, however, carefully worked down by the left index finger inserted within the gut, and to all appearance completely extirpated. Douglas' pouch was necessarily opened, and as the patient immediately had a bad fit of coughing, most of the small intestine at once protruded. It was returned and kept in place, with the able help of Mr. Sylvester Willard, who was kindly assisting me, by a flat sponge; while the large peritoneal fissure was sewn up with silk. The rectal mucous membrane was sutured to the skin posteriorly, the huge cavity in front being packed with iodoform gauze, and a catheter left in.

(a) Read at meeting of British Gynecological Society, May 10, 1900.

The patient never had the slightest bad symptom. The specimen is exhibited, and with it a photograph of the cicatrising chasm on the twenty-second day after operation. The intestinal mucous membrane is seen at the posterior angle of the wound; a circumstance rather exceptional, though distinctly advantageous. The temperature-chart shows the favourable convalescence and proves the absence of shock after a severe operation.

Remarks.—There are two points in connection with these cases which I desire specially to submit for consideration. The first is that both were passed by—one at a special hospital, the other by a private doctor—as wholly beyond the reach of operative measures. I imagine that the profession at large has hardly yet learnt to regard the higher regions of the rectum as lying within the scope of practical surgery. Yet so long as the gut remains mobile, cancerous disease of very long standing can be here removed; and, as in the infiltration, which appears “woody” to the touch, secondary deposits occur but tardily, can often be permanently eradicated. The female sex has in this matter an important advantage over the male, seeing that the bladder is so much less prone to infiltration.

The second point is that, by manipulation, the dissected part can nearly always be brought down and safely excised, without any interference with the bony structures. Personally, I have never yet seen a case of rectal cancer wherein excision was feasible at all, which could not be satisfactorily dealt with in the manner above indicated, without resort to the heroic operations of Kraske, Madelung, and their numerous imitators. I should be sorry to lay this down, however, as a rule without exception; and I only venture to suggest it with the utmost respect for the surgical skill of those fellows of the Society who, to my knowledge, most ably perform those operations.

Transactions of Societies.

CLINICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, MAY 25TH, 1900.

Sir R. DOUGLAS POWELL, Bart., President, in the Chair.

GASTROENTEROSTOMY FOLLOWED BY PYLORECTOMY.

MR. ARTHUR E. BARKER read notes of the case of a woman, *æt.* 55, who presented herself in March, 1899, at University College Hospital with very obscure symptoms of partial intestinal obstruction. There was a defined tumour to the left of the left rectus muscle under the border of the ribs. This was variously diagnosed, but the author held it to be a growth of the splenic flexure of the colon. The abdomen was opened on this hypothesis, also the left border of the left rectus. The tumour was found to be a carcinoma of the pylorus. Retrocolic gastroenterostomy was at once performed from which the patient made a rapid recovery. Five weeks later Mr. Barker removed the whole of the pyloric end of the stomach, and closed the resulting openings in it and in the duodenum. Recovery was rapid, and the patient put on flesh steadily and went about as before, eating, as a rule, ordinary food. She died of recurrence one year to a day after the operation. The first operation was done under local eucain analgesia, the second under chloroform anaesthesia. Murphy's button was employed and came away on the twelfth day. The operation was much facilitated by taking it in two stages.

Mr. LEONARD BIDWELL agreed in preferring the double operation, and he quoted some cases in which he had operated in that manner, all of which could be regarded as successful, though the growth had recurred later. In one case in which he had performed the operation in one stage the patient died within 10 days of the operation from the adhesions of the jejunum which resulted in a kink. To prevent this accident the loop of the jejunum attached to the stomach, he suggested, should not be too close up to the duodenum. If it were, regurgitation of the bile into the

stomach occurred. He advocated Halsted's method of suturing, and in only one case had he had the slightest trouble afterwards. The interval of time he had allowed between the two operations was 18 days, which he thought was a suitable time. In regard to the diagnosis of the early stages of stricture of the pylorus, there was at first increased power in the stomach muscle, and therefore no dilatation. The absence of dilatation of the stomach thus rendered the diagnosis more difficult. The prolongation of life was not very marked, but it was longer after the double operation than after gastroenterostomy alone.

Mr. BARKER, in reply, said he would have liked to have heard more particulars of Mr. Bidwell's cases. As to the prolongation of life, he was not very sanguine. The average duration of life was not seven years, but perhaps two or three years. Everything depended on an early diagnosis and the courage of the patient to undergo this operation. In any event, pylorotomy should never be done for anything excepting malignant disease.

Dr. W. F. VICTOR BONNY (introduced by Dr. Abercrombie) read a paper on a case of

OBSCURE SEPTICÆMIA TREATED BY ANTI-STREPTOCOCCUS SERUM AND NUCLEIN.

The case was that of a young man who was seized, without any history of previous disease whatsoever, with fever, of a persistent type, associated with joint swellings femoral thrombosis and abdominal distension. On the forty-second day of the disease, rigors began with a remittent temperature reaching nearly 107° on several occasions. He was treated by injections of anti-streptococcus serum, receiving within a period of 17 days 420 cubic centimetres in 42 injections. During this period the temperature fell, and the patient greatly improved. A relapse on the 64th day was treated by injections of nuclein 1 per cent. solution in two cc. doses. He received nearly 30 cubic cc. in eight days, during which period the temperature fell and the patient rapidly convalesced. He recovered, and was now in complete health. The diagnosis, which was obscure at first, was divided between malignant endocarditis, enteric fever, and some germ of obscure pyæmia. The first was negated by the absence of cardiac signs, the second by Widal's test twice applied. Several bacteriological emanations left the matter still unsettled, though Mr. A. G. Foulerton was suspicious of having detected the gonococcus in the blood, but could not, by a mishap, confirm it. Reviewing the whole case, the likelihood that it was a gonococcal septicæmia was not probable.

The serum used was that made by Mr. Bokenham, while Messrs. Burroughs Wellcome & Co. kindly gave the nuclein free. No ill effects followed the injection of either.

M. A. E. BARKER remarked that many cases of gonorrhœal pyæmia came under the notice of surgeons, and he would hesitate to accept the view that this case was checked by the anti-streptococcal serum. Cases of this disease often went on to an extreme degree, and then got well in a very remarkable way, without any remedy. The bacteria probably grew until the soil was exhausted.

Dr. BONNY, in reply to the suggestion that the recovery was a coincidence, remarked that the patient was getting progressively worse on two occasions, and each time when the remedies were given, he improved.

SEQUEL OF A CASE OF GRAVES' DISEASE WITH BRADYCARDIA.

Dr. WM. PASTRUP communicated the subsequent history and post-mortem notes of a case of Grave's disease with bradycardia shown at a clinical meeting in April, 1898. The patient, a widow, *æt.* 67, had suffered from Graves' disease for 20 years, and exhibited the disease in a typical form, with tachycardia, when first seen at the Middlesex Hospital in 1896. Under observation the enlarged thyroid dwindled and the tachycardia gradually gave place to marked bradycardia. The demeanour and facial expression were placid and almost apathetic. She said her voice had altered in quality. She had become very sensitive to cold and rather clumsy with her fingers. It

was a question whether the bradycardia was associated with degenerative lesions of the heart of which there was physical evidence; or whether, with other symptoms just mentioned, it indicated the supervention of myxœdema. The latter was the opinion generally expressed. The patient was readmitted to hospital in July, 1899, with acute symptoms of heart failure from which she rallied for a time. In January, 1900, she returned to hospital in a critical condition with signs of extreme tricuspid regurgitation and died within 24 hours of admission. The thyroid gland was rather small but not atrophic to the naked eye. Microscopically parts of the gland appeared fairly healthy, but others showed an extensive round-celled infiltration of the alveolar structure. There was hypertrophy and dilatation of the left ventricle of the heart, but little change was present at the valves and in the coronary arteries. The thymus was not persistent. There were no obvious changes in the brain or meninges. Dr. Pasteur considered that the case afforded valuable pathological evidence of the occurrence of thyroid atrophy in the wake of Graves' disease. The case was of interest in presenting the symptoms of the two diseases in combination. He was of opinion that the bradycardia was more probably related to the condition of the heart than to the thyroid cirrhosis.

Dr. ALEX. MORRISON thought that probably the bradycardia was related in some way to the thyroid disease. He asked if any notable effect resulted from treatment, and if it had modified the pulse in any way. The degenerative changes found in the heart were those constantly met with in opposite conditions of the pulse, and could therefore hardly account for the bradycardia. A systematic examination of the nervous system ought more constantly to be made in these cases. His own belief was that they would never be able to speak positively until the nerves' association with the heart could be investigated.

Dr. PASTEUR, in reply, said the nervous system had not been investigated in his case. As to the results of treatment by thyroid they were negative, and this was not surprising, seeing that so much colloid was found in the thyroid.

BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD THURSDAY, MAY 10TH, 1900.

W. J. SMYLY, M.D., President, in the Chair.

SPECIMENS.

Dr. WILLIAM WALTER (Manchester) showed a specimen of "myoma uteri removed by enucleation after colpotomy, and section of the uterus."

Dr. FRED EDGE (Wolverhampton) showed "two specimens of myoma uteri removed by vaginal hysterectomy."

Dr. F. WINSON RAMSAY (Bournemouth), and Dr. ARTHUR GILES showed a "uterus with multiple stalked fibrocystic tumours invading the broad ligament," illustrated by microscopical preparations.

In the discussion on these specimens,

Dr. CUTHBERT LOCKYER said that a careful examination of the last specimen led him to concur in the view expressed by Dr. Giles, that these remarkable polypoid growths were fibro-cystic in character. He thought that the specimen was unique, as he had never seen or read a description of similar growths invading the broad ligament. The portion of the growth in the uterine wall was relatively soft, whilst the polypoid portions were considerably firmer.

Dr. MACNAUGHTON-JONES, referring to Dr. Walter's specimen of myoma removed by enucleation, said that, except in the case of pedunculated fibroids, he had not removed these tumours by enucleation. But the view put forward by Dr. Walter was now, he thought, coming to be looked on as the right one, especially in America. Howard Kelly, in his book, expressed the opinion that, whenever it was feasible, enucleation was the classical operation for fibroids, and mentioned a considerable number of cases in which he had enucleated the myomata, and preserved the uterus. His own feeling had been otherwise, namely, that in dealing with

myomata, the best practice was to remove the uterus. He admitted, however, that the paper read last year before the Society, by Dr. Alexander, was, in many respects, very convincing.

The PRESIDENT observed that his feeling was that panhysterectomy was the best operation for myomata. Enucleation might have to be followed by further operations, and this seemed to him a very undesirable and unfortunate result.

Dr. WALTER, in his reply, said that the scope of enucleation appeared to him to be limited, to cases in which the uterus contained one or two tumours. When half-a-dozen or more tumours had to be removed, the uterus was likely to be much injured; and an important objection arose not only from the fact that some of the tumours might be left behind, but also because of the immediate danger of the operation due to mauling of the uterus. On the other hand, there were cases when after removal of the whole uterus one felt that the growth might easily have been enucleated. In this case he made an effort in the first instance to enucleate; and from the fact that after the preliminary attempt the patient showed no bad symptoms, he felt that there could at least be no harm in trying this plan first in some cases. If a further and more radical operation were needed, all that was necessary was to bisect the uterus and remove it in two halves.

Dr. FRED EDGE said, in reply, that perhaps he was inclined to take an extreme view; but all that one could do, was to follow the teachings of one's own experience. In the last three years he had seen in the practice of his colleague, Dr. Christopher Martin, three cases in which malignant disease occurred in the stump of the cervix left after supra-vaginal hysterectomy; the first operation had in each case been performed by means of clamps, by the late Mr. Lawson Tait. He had himself met with three cases in which a patient had a moderate-sized myoma with but few symptoms, so that he advised against operation; and in each case the patient returned within a short time with malignant disease. These cases had led him to determine that in every case of myoma with at least two or three tumours he would advise and practise the removal of the whole thing by panhysterectomy.

Dr. WINSON RAMSAY and Dr. ARTHUR GILES showed a specimen of ovarian papilloma invading the uterus through the broad ligament.

Dr. CUTHBERT LOCKYER said that the growth had apparently passed along the Fallopian tube without forming any attachments to it; but it had formed an attachment to the uterus at one point, burrowing through the mucosa into the parenchyma in that situation.

Dr. WILLIAM WALTER said that this growth appeared to be unique, he would suggest the question whether the disease could have arisen in the uterus itself? Such a view was supported by the fact of the attachment to one part of the uterus, and by the adenomatous character of the growth.

Dr. HERBERT SNOW considered that there were no vaguer words in pathology than "papilloma" and "adenoma." There was a point about papillomata which he had never been able to understand, and that was why such a growth in one tube should always infect the tube on the opposite side; he had always thought that the channel of infection was formed by the lymphatics. Might not the growth in the uterus in this case have arisen from rupture of the lymphatics in the uterine wall? It was the custom in operating on such cases to remove the diseased appendages and leave the uterus; but the specimen before them pointed to the fact that this practice might leave a considerable part of the disease behind.

Dr. FRED EDGE suggested that this might have been a polypoid growth with a long thin pedicle, arising from the ovary, passing down the tube and effecting an attachment to the uterine wall. Or it might perhaps have started in the ovary and uterus independently.

Dr. MACNAUGHTON-JONES thought that such a specimen pointed to the desirability of having a standing pathological committee, to which all rare and interesting specimens might be referred.

Dr. EDGE remarked that such a committee would be a great boon to the country Fellows of the Society.

Dr. ARTHUR GILES, in reply, said that he agreed with Dr. SNOW as to the vague way in which many terms were used in pathology. He had applied the term papilloma to this growth in reference to its naked-eye form; and the term adenoma in reference to its microscopic characters, which were those of a glandular structure. He further qualified the adenoma as being, in his opinion, malignant, because of the irregular way in which the glands had proliferated and invaded surrounding parts. He thought that Dr. Edge's first suggestion as to the mode of growth of the tumour was the most probable one.

Dr. HERBERT SNOW read a short communication on "Notes of Two Cases of Recto-Vaginal Excision for Cancer," which will be found under the head of "Clinical Records," page 549.

Mr. CHARLES RYALL congratulated Dr. SNOW on the results of his two cases. As far as prognosis was concerned, the surgery of cancer of the rectum was hopeful. As to the method adopted by Dr. SNOW, he would point out that there were many cases of cancer of the upper part of the rectum which could not be dealt with without removal of the bony parts. In a case he had reported at the British Medical Association, twelve inches of the upper rectum and sigmoid were removed. The high operation had the further advantage that one had not to work in the dark.

Dr. WINSON RAMSAY raised the question whether it was better to leave the opening of the bowel below, or to perform an inguinal colotomy. He believed that the latter was much more comfortable for the patient. In a case in which he had to remove the greater part of the lower bowel he adopted the plan of doing an inguinal colotomy first.

Dr. HERBERT SNOW, in reply, said that he was sure that there were many cases in which the growth could be removed without touching the bony structures, as long as the rectum was mobile and could be brought down. He had a great prejudice against inguinal colotomy, because he had seen several deaths from it. He much preferred lumbar colotomy, because by that means they could get at least two inches higher up the bowel; and also because the control of the artificial anus was better, the opening being in a more suitable situation.

Dr. HERBERT SNOW exhibited a uterus removed by vaginal hysterectomy for cancer of the cervix. The patient was a young married woman, aged thirty, and the disease was of three months' duration. The specimen illustrated the early and favourable stage of carcinoma, at which alone a radical cure might reasonably be anticipated from the operation. It was useless to operate when there was infiltration of the vaginal *sub mucosa*, or broad ligaments. The woman now had excellent health, but displayed a condition Dr. SNOW had not met with previously. There was a soft, fleshy knuckle, apparently of omentum, embedded in the vaginal cicatrix, and from this about a drachm of clear, non-odorous fluid exuded every morning.

A paper by Dr. MACPHERSON LAWRIE, of Weymouth, was read, on

THE INDICATIONS FOR THE REMOVAL OF THE UTERINE APPENDAGES.

which will be found under "Original Communications," page 543. The discussion on this paper was postponed to the following meeting.

LARYNGOLOGICAL SOCIETY OF LONDON.

MEETING HELD FRIDAY, MAY 4TH, 1900.

Sir FELIX SEMON, M.D., in the Chair.

CASES AND SPECIMENS.

Dr. LOGAN TURNER showed a specimen of a larynx with acute oedema. The oedema had supervened suddenly in the course of phthisis, and caused death from asphyxia before surgical assistance could be obtained.

Mr. STEPHEN PAGET showed a case of compression of the trachea by an enlarged thyroid gland.

Mr. ACLAND (introduced by Dr. Watson Williams

showed some new instruments for the treatment of empyema of the antrum, and Dr. WATSON WILLIAMS showed a new form of universal laryngeal forceps.

Dr. JOHNSON HORNE showed a case of inflammation of the crypts in the mucous membrane of the roof of the naso-pharynx.

Dr. LAMBERT LACK showed a curtain ring which he had removed from the pharynx of a child, *et. 9*, who had swallowed the ring at the age of nine months. Dr. LACK also showed two cases of nasal polypi treated by a new radical method, together with microscopic sections of portions of the bone removed. One of the cases operated upon eighteen months previously for unilateral polypi and purulent discharge, had since remained free from all symptoms.

The method of operation was discussed by Drs. SPENCER, WAGGETT, HILL, PARKER, SCANES SPICER, DUNDAS GRANT, PERMEWAN, and the President.

Dr. TILLEY showed (1) a case of chronic ethmoiditis simulating the so-called "cleavage of the middle turbinate"; (2) a case of external operation for chronic frontal sinus suppuration in an unusually large sinus.

Dr. EDWARD LAW showed a case of laryngeal ulceration; and Dr. POWELL one of ulceration of the epiglottis for diagnosis.

Dr. DUNDAS GRANT showed a case of enlarged gland in the neck associated with oedema of one arytenoid; also a case of laryngeal growth.

Dr. W. H. Kelson showed a case of laryngeal growth; Mr. Wyatt Wingrave a case of double abductor paralysis, with paresis of palate, &c.; Dr. Davis showed a case of enlargement of lingual tonsils in a woman suffering from secondary syphilis; Dr. Furniss Potter a case of pharyngeal and laryngeal ulceration, with microscopic sections of pieces removed; and Mr. Paget a case of ulceration of the larynx and of the upper lip, probably tertiary syphilis.

BRITISH LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL ASSOCIATION.

GENERAL MEETING HELD FRIDAY, MAY 11TH, 1900.

The President, Dr. BARCLAY BARON, in the Chair.

Dr. JOHN MACINTYRE (Glasgow) gave a demonstration upon the use of the

RÖNTGEN RAYS IN THE DIAGNOSIS OF DISEASES OF THE THROAT, NOSE AND NEIGHBOURING ORGANS,

illustrated by numerous lantern-slides, photographs and apparatus. In the first part he dealt with certain matters of technique, alluding especially to the advances made since his last demonstration to the Association in 1896. After speaking of the most convenient source of electricity, and discussing the relative advantages of Wimshurst machines and coils for Röntgen ray work he mentioned various forms of interrupter, including the Wehnelt, and a form devised by himself. He also described various modes of controlling the vacuum in Crook's tubes, and an ingenious automatic mercurial pump used by him when making his own tubes.

A discussion followed. We hope to publish a full report of this valuable paper and demonstration in an early number.

GENERAL MEDICAL COUNCIL.

SIXTY-NINTH SESSION, TUESDAY, MAY 22ND.

Sir WILLIAM TURNER, President, in the Chair.

THE Spring Session of the Council was inaugurated on Tuesday, May 22nd, by the usual address. The President announced that Sir William Thomson would not be able to attend, he being at the seat of war. Dr. Leech was also prevented attending by severe illness. Sir Hugh Beevor having been introduced as the representative of the Society of Apothecaries and Mr. H. Power as crown member in succession to the late Sir Richard Thorne, the PRESIDENT sketched the work with

which the Council would be called upon to deal. He reviewed the changes that had taken place in the *personnel* of the Council since their last meeting, and mentioned that they would have to provide for a successor to Mr. Farrer, the Council's solicitor, who contemplated retiring.

He then referred to certain changes in the Standing Orders which he thought experience had shown to be called for to regulate the debates. One important modification will bear on a means of cutting short a debate by the application of the closure.

The President was able to give satisfactory assurances with regard to obtaining additional powers for penal and disciplinary purposes, and a Bill with this object in view is to be introduced into Parliament at the first convenient opportunity.

After a few remarks about the present state of the midwives legislation, he referred to the question of reciprocity with Italy in regard to medical practice. He pointed out that the Medical Act gives no power to the Council to restrict the rights of persons admitted to registration in the foreign list in respect of medical practice, and he asked for an expression of opinion from the Council on the present aspect of the matter. He stated that it was hoped that a Bill amending the law bearing on death certification would be introduced during the next session of Parliament.

The President then alluded briefly to sundry other topics which would be brought before the Council, and the usual vote of thanks was accorded to him for his address.

After some formal business had been got through, the Council proceeded to discuss the

AMENDMENT OF STANDING ORDERS.

Briefly resumed, the alterations, which were carried without serious discussion, provide for the closure of a debate by vote without discussion. Dr. MACALISTER, who brought them forward, stated that the new rules had been modelled on those of the London County Council.

PENAL AND DISCIPLINARY POWERS.

The President then presented his report on the further steps taken by him to secure increased penal and disciplinary powers both for the Council and for the medical authorities represented on the Council, together with a draft bill with that object in view. This Bill gives the Council power in certain cases to erase from the *Medical Register* names of registered practitioners for a limited period and to restore the same. It will give the power to every medical authority to revoke, suspend the use of, or cancel their respective diplomas of persons whose names have been erased by order of the Council, and it will provide for the allocation of fines inflicted under the Medical Acts to the Council instead of the police as heretofore. The Bill, it is hoped, will receive the support of the parliamentary representatives of the various universities of the United Kingdom.

A resolution thanking the President for his action in the matter, and encouraging him to continue his efforts, was agreed to.

RESTORATION OF NAME.

The name of Mr. Samuel Frederick Murphy was ordered to be restored to the *Register*, and the Council then adjourned.

SECOND DAY, WEDNESDAY, MAY 23RD.

INTERIM REPORT OF MIDWIVES BILL COMMITTEE.

Dr. GLOVER brought forward an interim report setting forth the action of the committee since the last meeting. It having been represented to the Privy Council that a clause should be introduced requiring that a licensed midwife should obtain medical assistance in certain cases, the Lord President had replied advising that this could best be dealt with by a rule under Clause 4. The committee having reconsidered the matter, had adhered to the view that the point was one which ought to be dealt with by a special clause and had formulated certain amendments to the present Bill expressly withholding from licensed midwives the

right to attend cases of abnormal labour, and the assumption of names, titles or designations which might be construed to imply that she was a medical practitioner or could grant any certificate of death or still birth, also that she should not be licensed until she had furnished evidence of good character. After considering these suggestions, the Lord President of the Privy Council reiterated his opinion that it was not only unnecessary, but would be inconvenient, to deal with these points in the Bill seeing that the Council was in a position to secure these rules being passed. Thereupon the committee decided not to press the matter, the resolution embodying this decision being, however, objected to by Mr. Horsley. The Committee, however, insisted on the desirability of requiring evidence of good character, and also of defining the term midwife to mean "a woman who undertakes for gain to attend women during the lying-in period."

Dr. McVAIL wished the Council to go into committee on the Bill as a whole, but this Dr. Glover objected to.

Dr. GLOVER then proceeded to discuss certain points of the Bill actually before Parliament calling for amendment, and defended the position of the Committee in withdrawing their opposition.

Mr. VICTOR HORSLEY disapproved of the report, pointing out that they had no assurance that the Council would be able to insist on the Midwives' Board adopting these rules, and he urged the Council not to go back on the position taken up in 1898. He urged that the new definition of midwife was an absolute contradiction in terms, and he thought the Council was too easy-going in regard to the matter altogether, moreover he thought the officials of the Government did not receive the suggestions of the Council with that cordiality which they had a right to expect.

Dr. MACALISTER agreed on the importance of the points raised by Mr. Horsley, but rallied to the view that they could be better dealt with by a rule to be approved by the Council. He urged that in going to Parliament it was better policy to get Parliament to give some responsible body the power to enforce a principle rather than lay down in so many words a particular law, as that left more latitude for modification and improvement.

Sir CHRISTOPHER NIXON concurred in the remarks which had fallen from the last speaker, pointing out that they were all as convinced as Mr. Horsley of the importance of the points that had been raised, the only difference of opinion being as to the possibility of arriving at the desired result by a rule instead of a specific enactment. He pointed out that the Council would have the power to direct the Midwives' Board to frame rules so that the Council could secure what they wished in regard to the attendance of a medical practitioner in certain specified cases.

Mr. HORSLEY then proposed an amendment, withholding approval from that part of the report which provided that the first resolution of March 21st should not be pressed on the Government. This was seconded by Mr. GEORGE BROWN, who feared that if this particular resolution were not incorporated in the Bill, the Midwives' Board might hold that they had no power to put forward such regulations. It was one thing to frame rules compelling midwives to call in medical aid under certain circumstances, and quite another to impose penalties for not doing so.

Dr. ATTHILL thought it would be dangerous to push the resolution. He confessed that he did not like the Bill, but thought it was the best they could get, and probably the least injurious to the profession.

Dr. McVAIL did not think the needs of the case would be met even by the amendment, but he thought it was to be preferred to Dr. Glover's resolution.

The President agreed as to the importance of the subject, but pointed out that Parliament could not be expected to go into such questions, as the definition of natural labour and abnormal labour. He urged that the expressed opinion of the Lord President was entitled to consideration, and he thought that the Bill gave the required safeguard. Personally he should vote against the amendment. This was put to the vote and was negatived by a large majority.

Mr. GEORGE BROWN then moved that Clause 4, sub-clause 1 of the Bill, be altered to read as follows:—"Five registered medical practitioners, two to be appointed by the Royal College of Physicians of London, two by the Royal College of Surgeons of England, and one by the Society of Apothecaries."

After an ineffectual attempt to shelve this resolution by moving "the previous question," Dr. MACALISTER urged that it would be very unwise for the Council to go back on previous decisions to this extent.

Sir CHRISTOPHER NIXON raised the question whether, if the Council adopted the interim report, they would not be adopting the Bill now before Parliament, to which the PRESIDENT replied that the Council was only committed to those parts of the Bill which embodied resolutions carried by the Council.

The motion was then negatived.

It was then agreed to forward a copy of the report to the Lord President of the Privy Council, and to inform him that the Council had approved the steps taken by its Committee.

PERSONATION.

Mr. VICTOR HORSLEY moved that counsel's opinion be taken on the possibility of preventing by legal action under the existing law, or, if necessary, by amendment of the Medical and Dentists' Acts, fraudulent personation of registered medical and dental practitioners. He mentioned that the Director of Public Prosecutions had given it as his opinion that personation of a registered practitioner was not a criminal offence, though such a person could be attacked indirectly.

The motion was carried, and it was arranged that Mr. Farrer should be requested to prepare a case and submit it before it went to counsel.

The Council then went into Committee to consider the report by the Committee on the Prevention of Personation adjourned from December 4th, 1899.

Mr. HORSLEY, as chairman of the Committee, pointed out that they advised the institution of a regulation whereby identification should be procured by means of handwriting, a method which had already been resorted to since the drafting of the report by the English Branch Council and by the Registrar himself. All that would be necessary would be that the applicant should enter for himself, in his own handwriting, the particulars of his status. With regard to restoration of names the Committee recommended a new standing order and a form of statutory declaration to be furnished by the person requesting restoration. The method might involve a little delay in re-registration, but that was unavoidable. He adopted Sir Richard Thorne's suggestion that before erasing a practitioner's name for non-reply to letter of inquiry, the Registrar should address a registered letter containing a stamped envelope to a registered practitioner in the district inquiring whether or not the practitioner from whom no reply had been received was or was not resident in the neighbourhood. Lastly, the Committee felt that the existence of certificates of registration constituted the greatest danger to the *Register*, and the Committee advised that the issue of such certificates of registration should be discontinued. If necessary, the Registrar might be empowered to address to a body, for example, seeking to appoint a medical man whose name did not yet figure on the *Register*, a letter to the effect that "the following is a correct copy of the entry in the *Register* of the current date such certificates only being valid until the next annual issue." Such a document could at worst only be misused for a few months. The Committee concluded with the recommendation that a complete set of resolutions governing registration be drafted by the Council.

The PRESIDENT thought the question of identification by handwriting was a serious matter, and at his suggestion the discussion was adjourned in order that the memoranda prepared by the three registrars on this subject might be circulated among members of Council.

THE SUCCESSOR TO MR. FARRER.

It was referred to the Executive Committee to consider the question of the appointment of a solicitors to

the Council in succession to Mr. Farrer, and to report to the Council during the present session.

ELECTION OF REPRESENTATIVES OF LICENSING BODIES.

A communication from the County of Durham Medical Union in regard to the method of appointment of representatives of the licensing bodies on the Council was formally communicated to the Council.

The Council then adjourned.

THIRD DAY.—THURSDAY, MAY 24TH.

CASE OF WILLIAM MATTHEWS JOYCE.

The case of William Matthews Joyce, which was adjourned from the last meeting of the Council, came up for consideration. After some delay, Mr. Joyce put in an appearance, but he had not provided himself with any evidence of subsequent good behaviour "becoming a medical man." The unhappy man had apparently nothing to say for himself, so the Council proceeded to deliberate *in camera*, and in about half-an-hour, strangers having been re-admitted, it was announced that his name had been ordered to be erased from the *Register*.

RESTORATION OF NAME.

After a few minutes' debate *in camera* the name of George Ingersoll Curragh was ordered to be restored to the *Register*.

CASE OF JAMES ALEXANDER GRAYDON.

The next case to come before the notice of the Council was that of James Alexander Graydon, of Bow Road, registered as a Lic. Fac. Phys. Surg., Glasgow, 1870, who appeared by reason of his conviction for assaulting his wife, Henrietta Graydon, while in a state of drunkenness.

Several letters were read, among them being one from his wife, imploring the Council not to strike her husband off the roll, and another in which the defendant stated that he had been a total abstainer for ten weeks. Questions were put to him by various members of the Council, from which it transpired that he was not in practice, and had not been for over a year, the reason alleged for this being the competition of an excessive number of dispensaries in his neighbourhood. On replying in the negative to the President's question as to whether he had anything to say for himself, strangers withdrew, and the Council adjourned the further consideration of his case till the next meeting, when Mr. Graydon will be required to produce satisfactory evidence of his good conduct by written certificates, one of which, at least must be delivered by a medical practitioner.

CASE OF ARMITAGE FORBES.

The next case was that of Armitage Forbes, of 28, Charlotte Street, Ashfield, Sydney, New South Wales, registered in Ireland in 1879, as L.R.C.S.I., 1878, L.R.C.P. Ed., 1879; who was charged with being associated with the Anglo-Australian Medical Institute, and allowing his name and qualification to be used in connection with the public advertisements of systems of treatment and remedies for particular diseases, such advertisements being of a discreditable nature.

Mr. Forbes did not appear in person, but a letter was read in which he denied that his name had appeared in any newspaper except in connection with the Anglo-Australian Institute. He intimated that as soon as he received the summons from the Council, the Institute was closed, and all pamphlets in connection with it were withdrawn from circulation and destroyed. He hoped in consequence that his name would not be erased.

The PRESIDENT suggested that Mr. Forbes's letter should be sent to the Queensland Medical Board for corroboration of the statement regarding the closure of the Institute, &c.

Dr. MACALISTER observed that the Queensland Medical Board was dependent on the General Medical Council and could not therefore sit in judgment before the General Medical Council had taken the first step.

After a sharp protest by Mr. VICTOR HORSLEY against repeated interruptions by Dr. MacAlister, Mr. Horsley suggested that the matter be dropped for the present.

Dr. MACVAIL argued that it was quite unnecessary to consult the Queensland Board, when advertisements such as had been passed round had been issued. Thereupon the Council proceeded to deliberate *in camera*, decided to erase the name of Mr. Armitage Forbes from the *Register*.

CASE OF ARTHUR OGLESBY.

This was the case of a dentist which had been referred to the Dental Committee for investigation and report. The Committee reported that Mr. Oglesby was registered as having been in practice before July 28, 1878; that he resorted to systematic advertisement of an objectionable nature.

The case was then considered, and Mr. Oglesby appeared and addressed the Council. Ultimately his name was ordered to be erased from the *Dentists' Register* as guilty of "infamous or disgraceful conduct in a professional respect."

The Council then adjourned.

FOURTH DAY.—FRIDAY, MAY 25TH.

CASE OF OWEN MCBRIEN.

This was another dentists' case, in which the defendant was found guilty of "conduct which is infamous or disgraceful in a professional respect," and his name was ordered to be erased from the *Dentists' Register*.

CASE OF CHARLES LOUIS LUMLEY.

This was a very peculiar case, Mr. Lumley (who is registered as L.R.C.P.I.) being charged with having sought fraudulently to obtain from a Mr. Balmer certain sums of money in payment of services rendered to Mrs. Balmer, whereas he had never rendered such services or attendance.

The charge was based mainly on evidence given in the Divorce Court, in which Mr. Lumley was the co-respondent and was found guilty of adultery.

Mr. Lumley appeared in person, accompanied by Mr. Roskell, his counsel. The facts were not really called in question, but it was urged by counsel that Mr. Lumley had only committed a serious indiscretion, of which the Council was not called upon to take cognisance. He had yielded to the persuasion of Mrs. Balmer, who had represented to him that she could only obtain money from her husband by showing that she had been ill, and had made out a bill for medical attendance, but he had subsequently asked for the bill (which, it was stated, had never been sent in to the husband) to be returned, and had been given to understand that it had been destroyed.

After prolonged examination and deliberation, Council adjudged Mr. Lumley guilty of the charge brought against him, and ordered his name to be erased from the *Medical Register*.

CASE OF ANDREW ALEXANDER.

The Council next proceeded with the case of Andrew Alexander, of Blaydon-on-Tyne, accused by the Gateshead Medical Association of covering an unqualified assistant, named Tait.

Dr. Bateman, who appeared on behalf of the Association, stated in a few words that the object of this society was to promote good conduct among practitioners. Alexander had a qualified assistant, named Thompson, who left him suddenly for no particular reason, whereupon he advertised for an assistant but could not get one, and after some trouble Tait came to him, it was asserted by the defendant, in the capacity of a pupil.

Three witnesses were called by Dr. Bateman—one a Mr. Alfred Cox, the honorary secretary of the Association, Dr. Davies, who practises in the same district, and a man called Dover, who was attended by Tait in Dr. Alexander's surgery, and gave evidence to the effect that Tait gave him a certificate purporting to be signed by Dr. Alexander, and when Tait was tearing it off he noticed that the following one was signed also. Mr. Horridge, who appeared for the defendant, cross-questioned the witnesses. It transpired that in a letter written by Mr. Alexander (in answer to one from Dr. Bateman), he stated that Tait was his pupil, and that he saw all cases himself accompanied by Tait, and that there was a telephonic communication between the surgery

where Tait lived and Dr. Alexander's private house. In one letter Dr. Bateman asked if Tait were a registered student, and if so at what hospital. To this no answer had been given. Mr. Horridge addressed the Council on behalf of the defendant, urging that from first to last his client had made no attempt to "cover" anything or anybody.

Certain documents which were to have been put in by Mr. Horridge were objected to on the ground that they were signed by people, in the name of 400 others, who were not present to be questioned.

Dr. Alexander, in answer to the question, what duties fell to Tait's lot, said they comprised dispensing, easy midwifery, visits of "policy and supererogation." He never represented Tait to his patients as a qualified man, and at a great number of public meeting he made known the fact how sorry he was that he could not get a qualified man. He added that Tait never signed any certificate of death or notification, but some were signed in blank for him to use in trifling cases, just as a magistrate was reputed to keep a bundle of summons signed ready.

Asked to define a medical student, he said it tallied very closely with that of an assistant. Tait was about 22 years old, and had been at the Maternity Hospital at Glasgow for a fortnight. Alexander denied having represented him as a registered medical student. Dr. Cameron, as a director of the hospital, said cases would never have been given to him unless he had been represented as such.

The further consideration of the case was postponed until the next day.

FIFTH DAY.—SATURDAY, May 26th.

The Council resumed the consideration of the case of Mr. Andrew Alexander *in camera*, and, on strangers being readmitted, the President announced that the charge against Mr. Alexander had been proved to the satisfaction of the Council, and that the further consideration of the charge had been adjourned until next session. This means that Mr. Alexander will have to appear before the Council in November, when he will do well to produce satisfactory evidence of having ceased to employ an unqualified person.

The remainder of the day was spent *in camera*, for the purpose of considering a report from the Penal Cases Committee.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, May 27th, 1900.

RETENTION OF URINE.

RETENTION of urine is caused in a large number of cases by a spasm of the sphincter of the urethra. Among such causes might be mentioned, retention following traumatism and operations bearing on the urino-genital apparatus, although the integrity and the permeability of the canal may have been perfect, or those operations have implicated the neighbouring regions (fractures of the pelvis, traumatism of the pelvic organs, contusions of the abdomen, intervention for hernia, hydrocele, &c); retention accompanying certain great traumatisms, retention of nervous persons, to which might be added certain reflex retentions of which the point of origin is a lesion of the urethra (bleorrhagia urethral), or in a lesion of the bladder (cystitic tuberculosis, &c).

The classical treatment of the retention due to spasm differed but little from that of other retentions, and consisted in, after fruitless attempts to pass a catheter, the administration of sedatives, and the local application of heat in the form of

poultices, enemas, baths, &c. Dr. Martel, hospital surgeon at St. Etienne, has published three or four cases of retention due to spasm of the sphincter treated by injections of cocaine with complete success. His method is as simple as it is intelligent. Considering on the one hand that the object of the old treatment was the relieving of the spasm and on the other that cocaine attained that end more effectively and more rapidly, Dr. Martel concluded to make the experiment.

His first case was that of a man who, working at a house in course of construction, fell from the fourth floor through the stairway. Picked up and brought to the hospital, it was found that he had not sustained injuries in proportion to his fall. He passed a good night, but in the morning he complained that he could not micturate. Examination showed that the bladder was distended. One drachm of a solution of cocaine (1-50) was injected into the urethra and retained two minutes, after which the patient urinated without difficulty. The following evening the same spasm set in, and another injection was given, with a like satisfactory result, and thus morning and evening for five days, when the man could relieve himself naturally.

In two other cases the retention was of reflex origin following operations, radical cure of hernia, radical cure of hydrocele, while the fourth supervened on fracture of the leg. The classical treatment was applied to all these without result, whilst a simple injection of cocaine caused the spasm to cease immediately.

Consequently, when in presence of spasmodic retention when poultices and enemas have failed, one is sure to promptly relieve the patient by an injection of cocaine, and in any case before attempting to pass a catheter, which is always liable to provoke infection. The only counter-indication to cocaine would be the existence of a wound in the canal produced by rupture or attempts at passing a catheter, as it permitted a too easy and too rapid absorption of the cocaine.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, May 26th, 1900.

At the Society for Innere Medizin, Herr Gluck read a paper on

THE SURGERY OF THE CIRCULATORY APPARATUS.

He said that during recent periods this had become enriched by several procedures, among which were temporary ligature of the main vessels, and then lateral and circular sutures. In the year 1882 he showed a case of traumatic aneurysm of the abdominal aorta, caused by a bullet wound, in which the sac was completely obliterated, the patient dying later on of pneumonia. The case led him to think whether it would not be possible to effect a cure by cutting away part of the aneurysmal sac, and then suturing. Animal experiment had shown that recovery could take place by lateral suture in case of rent of the vessel, and by circular suture in case of complete section of the vessel. He had shown this in 1881. Not a drop of blood trickled through after careful union with sutures. This idea, everywhere rejected at the time, had now nearly 20 years after been recognised as feasible in Von Bergmann Handbook of Surgery, where he said that with early diagnosis a portion of the sac wall might be removed, and the opening closed by suture. The speaker

believed that identical results could be obtained by the formation of folds.

The speaker then went on to speak of the treatment of thrombo-phlebitis by occlusion of the diseased vein, which had been already recommended by John Hunter. The case in which the procedure was carried out was that of a woman who for 14 years had suffered from cholesteatoma of the right external ear, and who had been repeatedly treated by specialists without result, as she would not submit to our radical treatment. In September, 1896, she was attacked with high fever, rigors, vomiting, &c., and erysipelas developed, starting from the ear, which suppurated. On October 9th, the mastoid was opened, and the steatoma removed. The erysipelas now improved, but the rigors continued frequent, delirium came on, and the temperature rose to 41°C. A diagnosis was made of pyæmia following septic thrombo-phlebitis of the jugular veins, and the speaker performed a second operation, opening up the region of the jugular, finding the sheath of the vessels filled with stinking pus. Nearly the whole of the petrous bone was resected, laying open the transverse sinus and the bulb of the jugular vein. The diseased portion of vein was incised between two ligatures, the internal carotid was opened at the operation, the opening being closed by suture. After this extended operation the temperature fell, the meningitic symptom subsided, and now, seven months after operation, the wound was quite closed. There was complete paralysis of the right facial nerve, however, which might be possibly improved by further operation, but the patient was contented with her condition and did not desire anything further. (The patient was shown.)

At the Surgical Congress, patients were shown on whom

SPLENECTOMY

had been performed by Hr. Bassel-Hagen, Charlottenburg. He considered splenectomy to be an admissible operation, and he had collected a series of 247 cases in which it had been performed primarily for leucæmia. The mortality in the first 120 cases had been 34 per cent., whilst in the last 127 it had been only 13 per cent. As regarded indications for the operation there was no difference of opinion in respect of severe injuries to the spleen, malignant tumour, wandering spleen with hypertrophy and pus collection; but there was not so much clearness in regard to malaria hypertrophy and idiopathic hypertrophy. Certain accompanying symptoms of tumours, such as disturbance in the blood formation, and marked cachexia were contra-indications. In extirpations for malaria spleen the mortality was about 10 per cent. In many cases surprising improvement took place. Further experience was, however, necessary. In extirpations of idiopathically enlarged spleen the mortality was 7 per cent.; the operation was to be performed when the enlarged spleen injured the liver, something that occurred more frequently than was believed. Lately special attention had been drawn to the association with cirrhosis of the liver, not due to alcohol but to an unknown infective process. Possibly in these cases the spleen was the first to be attacked, and the spleen then acting injuriously on the liver. If this hypothesis proved correct splenectomy would then be prophylactic of later developing disease of the liver. The speaker had performed splenectomy 15 times, with three deaths (one of the patients shown). She was a

girl of 26, out of a healthy family, and from a district free from malaria. As a child she had a large abdomen. For years she had had a large spleen reaching to the umbilicus, some enlargement of the liver and slight albuminuria; there was no ascites. The incision was made laterally from the middle line, the tumour was freed from its surroundings. There were large vessels in the gastrocolic ligament. The extirpated spleen weighed 2,050 grm., was 29½ cm. in length, 17 cm. in width, and 8½ thick. Recovery was favourable, except for pneumonia caused by the anæsthetic. The circulatory disturbance disappeared after the operation, and also the albumen; the blood still showed slight lymphocytosis. The speaker further reported on two other cases operated on. In one there was suppuration of the spleen, and in the other there were multiple abscesses. Both cases did well.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, May 27th, 1900.

CAPUT OBSTIPUM.

At the "Gesellschaft der Aerzte" this week, Gleich brought forward a case on which he had successfully operated for torticollis on the left side. The case was of a congenital nature. His plastic operation was somewhat the same as that practised by Foederl, who described twelve cases last week. Gleich cut the sternocleido-mastoid muscle at its peripheral ends, which were attached to the subcutaneous covering. Another plastic operation was subsequently performed to supply the defective muscle by taking a part out of the pectoralis major to complete the functional action of the cleido-mastoid.

NOSOCOMIAL GANGRENE.

Matzenauer gave a record of 22 cases of nosocomial gangrene in the genital region. By a microscopic examination he found embedded at a distance from the croupo-diphtheritic deposit on the ulcers a microbe 4 to 5 cc. in length, rounded at the ends, and of an anaerobic nature when cultivated. By vaccination the results were seldom successful.

Paltauf thought the cases described were not hospital gangrene.

Kiposi was of opinion that there were several varieties of gangrene with different ætiology.

Greinfeld was inclined to believe that the cases were identical with hospital gangrene.

Gussenbauer said there were several forms of hospital gangrene that could only be differentiated by the microscope and cultures, but he thought the cases described by Matzenauer were due to the inflammatory process proceeding from the ulcer. In such cases of gangrene as those described he found best effects from a subcutaneous injection of a 5 per cent. solution driven well into the healthy tissue of the periphery of the sore.

GLAUCOMATOUS EXCAVATION.

Schnabel next read a paper on the excavations met with in glaucoma. From a hundred cases carefully examined by himself and Elschnig 52 were glaucomatous, 18 were due to other diseases, while the remaining 30 were perfectly healthy. From these results he was perfectly convinced that Heinrich Müller's hypothesis is of pressure of the upper coverings of eye on

the lamina cribrosa being the cause of excavation could not be supported. Glaucoma was a disease that extended from the eye centrifugally and could be followed to the chiasma nervorum opticorum as a morbid degenerative process, in which occasionally the phenomena of a preceding inflammation (hyperæmia and cellular infiltration) may be observed. Through the breaking down and absorption of the degenerated tissue those excavations are produced, but we cannot say they are pathognomonic of glaucoma. Indeed a glioma tissue is often met with from the degenerate nerve; even fibrous tissue is not uncommon. The cavern formed in the intraocular part of the optic nerve is not due to a pressing back of the lamina cribrosa, but a destruction and absorption of the nerve tissue in front of the lamina cribrosa. Sometimes the cribrosa is decidedly bent backwards, but this is where the tissue has been absorbed in a similar manner on the internal side, leaving the lamina without support.

The degenerative changes may be considered to commence with the enlargement of the space, which becomes filled with a pathological fluid leading to a swelling of the nerve that resembles a neuritis optica. If fibrous tissue be formed at this stage of the process either partial or complete excavation is the result.

The anatomy of the nerve is also against the pressure theory, as it is hard to conceive a few fibres of the nerve being pressed on by a fibrous framework of tissue and affecting the whole nerve by the formation of a cavity. We must, however, distinguish between glaucoma from excavation pressure and secondary glaucoma. In cases where the pressure on the lamina cribrosa from before produces atrophy of the nerve, or secondary glaucoma, the atrophy is sharply defined to cease at that barrier which is not the case in ordinary glaucoma, which extends to the chiasma.

Whatever the cause of this atrophic excavation, it is certainly very rare as an anatomical change and never discovered ophthalmologically. What is described in books as a deficient parallactic displacement and difference of refraction as diagnostic is only pure fiction.

FEMALE EDUCATION ONWARD.

It is now ancient history to speak of the lady taking a medical diploma, but a further advance is pending, viz., the bar. Recently it has been quite correct for ladies to take the judicial classes at the university as an accomplishment, but Professor Bernatzki is now pressing for ladies to pass the state examination so that they may practise with plenary power in a court of justice.

Continental Notes.—The Savoy Spas.

[FROM OUR SPECIAL CORRESPONDENT.]

NO. III.—BRIDES-LES-BAINS SALINS MOUTIERS.

BRIDES-LES-BAINS and Salins-Moutiers are twin Spas; each with its bath establishment, but both under the same management, the two together forming a most important and thoroughly unique health resort. Brides and Moutiers are now connected by an electric tramway. The principal hotels and villa residences are at Brides, the chief hotels being the "Grand Hotel des Thermes," the "Hotel de France," the "Nouvel Hotel," and the "Grand Chalet." The well-equipped hydrotherapeutic establishment, the pretty Casino, and the reading rooms

are in the same park as the Grand Hotel des Thermes. The hotel has also very convenient private entrances to the baths. The village of Brides is delightfully situated in a valley 1,800 ft. above sea level in the Tarentaise Alps, the most Swiss-like of the Savoy mountains. At the head of this valley is the superb Pralogan glacier; and down the valley, in a torrent picturesquely broken by numerous cascades, rushes the Doron river. The low temperature of this pure river-water renders it, in some special cases, a powerful adjunct to the mineral waters in hydropathic treatment.

The mineral waters of Brides spring in a trickling stream from cracks in a quartz-magnesian schist, on the left bank of the Doron. Their specific gravity is $1\frac{1}{2}^{\circ}$ Baume; their temperature 95° F.; their mineralisation, 6.18 gr. per litre. They contain sulphates, chloride of sodium, and magnesia of iron. In each litre are 5.09 gr. of various purgative salts, as sulphate of soda, lime, magnesia, &c. Their output is over 80,000 gallons every 24 hours. In small quantities they are sparkling and colourless; in bulk they appear slightly ochreous. In pools this reddish-brown tinge is quite noticeable; and abundant deposits testify to the presence of iron. Their taste is flat, with a tendency to an ink-flavour. They are easy of assimilation, and can be freely taken (under medical direction) without injury. The average prescriptions vary from two to six glasses (of 250 grammes) daily. In small doses they are aperitive, yet tonic and invigorating; in large doses purifying and purgative (but not weakening and without colic pains) and remarkably diuretic, the urinary secretion being largely increased; the urine speedily becoming full, clear, and limpid, during treatment at Brides.

When a greater purgative result is desired, the action of the mineral waters of Brides can be readily increased by adding some of the Montier Salins water, or from two to five grammes of the "Salts of Brides."

Dr. Lefort says:—"The great peculiarity of the Brides waters is their inimitable union of purgative and tonic qualities. This double action favours the secretions, and the circulation of the digestive tube and its adjoining parts, without debilitating (as might otherwise be the case with saline purgatives often repeated), but, on the contrary, building up again the constitution by exciting appetite, and without injury to the state of the blood, or to nutrition, as with alkaline waters and carbonates of sodium." This combined tonic and purgative result accounts for the great benefit derived from "a cure" at Brides in liver complaints; in cases of anæmia; of debilitation from long residence in hot countries; and particularly in complications of liver and anæmia.

The principal resident physician at Brides, Dr. P. Delastre, specially recommends the Brides waters and treatment for diseases of the liver, uterus, and digestive organs; gastro-intestinal catarrhs, intermittent fevers, calculi, diabetes, and obesity. He says, "Chronic congestion of the liver, induced by gout or other cause, and patients who have contracted in hot climates intermittent fevers complicated with hepatitis (producing the well-known 'Indian liver') are treated with the best results at Brides; better indeed than at Vichy or Carlsbad, their usually anæmic condition requiring a therapeutic agent of an anti-congestive and at the same time of a tonic nature; and this is

exactly found in the double action of our Brides-Salins waters." He adds, "Chronic diarrhoea and dysentery contracted in hot climates yield to the Brides treatment and occasionally disappear as if by magic."

The basis of the Brides treatment is drinking the waters, and the pump-room is in the early morning the general rendezvous of the visitors. The general and special douches, sprays, &c., although admittedly beneficial aids, are regarded at Brides as auxiliary and subordinate to the internal use of the waters.

The Operating Theatres.

KING'S COLLEGE HOSPITAL.

RETRO-PERITONEAL ABSCESS.—Mr. CARLESS operated on a woman, æt. 26, who had been confined of her first child a month previously. The labour had been normal, and the puerperium uneventful; the discharge had never been offensive. Ten or twelve days before she had been seen pain was complained of running down the left leg, and it was thought possible that thrombosis of the iliac vein was imminent; the limb, however, remained of the normal size, and after a few days a lump appeared in the left iliac fossa. This gradually became larger, and its increase in size was concurrent with a development of febrile symptoms, the temperature running up to 102° or 103° every night. On examination, the lump in the iliac fossa was found to extend upwards and outwards above the anterior superior spine of the ilium, and very distinct fluctuation could be detected, in fact, it was evident that the fluid was close beneath the abdominal wall. Fluctuation was most definite in the region of the inguinal canal although the tumour was here found to be tympanitic. Per vaginam nothing abnormal was revealed, and there was none of the hardness so characteristic of pelvic cellulitis. Mr. Carless stated that although one's first thought would be to connect the abscess with the labour, yet the physical signs contra-indicated this connection, and therefore one would approach the case as one of acute iliac abscess of uncertain origin. The patient having been anaesthetised, and the parts shaved and purified, an incision was made over the spot where the fluctuation was most easily detected, namely, the outer part of the inguinal canal; the subcutaneous tissues were found to be infiltrated with fluid and slightly brawny, and it was only necessary to divide the external oblique aponeurosis in order to reach the abscess sac, which gave way before the pressure of the finger. As soon as an opening had been made there was an escape of highly offensive gas, followed by a flow of equally offensive pus. The opening in the sac was enlarged so as to admit the finger, and a curious little polypoid mass was felt closely resembling the vermiform appendix, indeed the precaution was taken to examine the chest and upper part of the abdomen, to make certain that the patient was not the subject of a transposition of viscera; the heart and liver were, however, found in their proper places. The cavity was now thoroughly washed out, and was found to extend down to a very limited degree, and not to encroach at all on the pelvic viscera; on the other hand, pus continued to well out from the upper part of

the wound, and it was only by enlarging the incision for another inch or more that a large pocket was found tracking up behind the colon, the opening into this was enlarged and the cavity freely flushed out with sterilised salt solution. A drainage tube six inches in length was passed up along this passage; another short one was placed in the lower end of the cavity, and both were stitched to the extremities of the wound, the central part of which was secured by sutures. Mr. Carless pointed out that no cause for this abscess had been detected, and that at the present time it would be very unwise to search for it. In all probability some communication with one of the hollow viscera was present, although nothing was to be found in the patient's preceding history indicative of such trouble; the most likely lesion was an ulcer of the posterior wall of the stomach, which, by its extension, had caused obliteration of the lesser peritoneal sac and had opened up the retro-peritoneal tissues. Mere gravity would explain the tracking of the abscess downwards to the iliac fossa. It is well known, he said, that gastric ulcers may produce very few symptoms, and yet it was certainly strange that such extensive mischief should be present without some symptoms being caused thereby. Mr. Carless hoped that, as the outcome of opening the abscess and removing the pus, reparative changes would occur in the walls of the abscess, which would lead to closure of the communication with the intestinal canal.

It is satisfactory to note that this hope has been fulfilled; the patient's progress has been uninterruptedly good; the temperature fell on the day of the operation to the normal level, and has since remained there; the discharge was sweet on the second day, and has gradually diminished, so that within three weeks of the operation the patient was allowed to sit up.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, MAY 30, 1900.

THE GENERAL MEDICAL COUNCIL.

THE prolixity of the debates is evidently inspiring apprehension in the bosoms of those entrusted with

their conduct, and sundry alterations in the Standing Orders have been agreed to, which, if judiciously applied, may do something to economise time. In future, it will be possible to apply the closure without having recourse to one or other of the artifices known to public debaters as a means of cutting short a troublesome discussion. On the whole, if we were asked to formulate our grievance against the Council, our ground would be not so much that matters are discussed at undue length as that, after a full-dress discussion, it so often happens that no tangible result is arrived at the old device of shelving matters by vague reference to a committee appearing to satisfy everybody. We may congratulate ourselves that there is now reasonable prospect of the penal and disciplinary powers of the Council being amended and extended so as to bring them into conformity with present requirements. It is indispensable that the Council should be enabled to call to account and punish, if thought desirable, persons who have been guilty of minor infractions of professional proprieties without declaring them to have been guilty of 'infamous conduct,' an expression which savours of the ridiculous when applied even to technical offences, such as "covering" and advertising. It is necessary also that practitioners whose names have been erased from the *Register* should be effectually prevented from continuing to practise, and for this purpose co-ordinated action is necessary between the Council and the degree- or license-conferring bodies. The somewhat urgent question of reciprocity of medical practice remains in a very unsatisfactory position, and it is not easy to see how it can be remedied so far as the Council is concerned. It is, of course, out of the question that we should concede the right to Italian medical graduates to practise medicine over here unless parallel rights are conceded to English medical men in Italy. We gather that the most we can hope for from the Italian Government is the concession, under certain conditions, to Englishmen, of the right to practise there among their fellow countrymen. No such restriction is possible over here, and even if stipulated, it could not readily be enforced. We would gladly see these finnikin restrictions abolished altogether, the public interest only requiring that measures should be adopted to secure a suitable standard of professional attainments on the part of foreign candidates for practice. It would be a thousand pities if this absolutely unique opportunity of introducing the principle of reciprocity should be allowed to fall through, and we sincerely hope that some means will be discovered of establishing a *modus vivendi*. We rejoice to think that substantial progress has been made in the direction of preventing personation. It comes as a surprise to know, on the authority of the Director of Public Prosecutions, that the act of personating a registered practitioner is not *per se* a criminal offence, and can only protest that it is high time it were made so. Even as matters stand at present, however, it must surely be

possible to provide more trustworthy means of identification than the purely formal measures actually in force. The handwriting affords one such means, but why should not the Bertillon system be applied and a summary description of the registered person be appended. Failing a more detailed description he might be invited to furnish his thumb mark, the whorls thereof are more stable in their distribution than even the salient features of a handwriting. Lastly, comes the question of midwives legislation. There is no difference of opinion on the Council as to the importance of requiring that midwives shall call in medical aid in all abnormal cases, and also that they shall furnish evidence of good character. The Lord President of the Privy Council opines that these and other objects can readily be attained by means of rules to be approved by the Council, and it would probably be idle to attempt to force the hands of the Government to get them inserted in the Bill. It is better to get a parliament to lay down principles and entrust their application to a responsible body than to crystallise certain formulæ which experience may promptly show to require revision.

THE COMING ANNUAL ELECTION AT THE ROYAL COLLEGE OF SURGEONS, IRELAND.

THE voting paper for the election of President, Vice-President, and Council of the college, which is to take place on the 5th of June, was issued to the Fellows last Friday. From it we learn that Mr. Myles, the Vice-President, is the only candidate for the Presidency, and he will, of course, occupy that office, certainly for one, most probably for two years. The Vice-Presidency is contested by Mr. Ormsby, of the Meath Hospital, and Mr. Heuston, of the Adelaide, and the competition seems to be very close. For the 19 seats on the Council there are 24 candidates, of whom 17 are outgoing Councillors who seek re-election, and 7 are either newcomers or have occupied seats at some previous time. The outgoing councillors are Messrs. Jacob, Bennett, Sir Ph. Smyly, Swan, Sir William Stokes, Swanzy, Sir William Thomson, Meldon, Sir Charles Cameron, Purefoy, Cranny, Sherlock, Story, Fitzgibbon, Lentaigue, Chance, and M'Causland. The candidates *ab extra* are Messrs. Hillis (Surgeon to the Throat Hospital, and formerly Medical Officer in the West Indian Government Service), C. B. Ball (Regius Professor of Surgery in the University of Dublin), Graves Stoker (Surgeon to the Whitworth Hospital, Drumcondra), Woods (Throat and Ear Surgeon to the House of Industry Hospitals), F. S. Morrison (of Dundalk), T. E. Gordon (Surgeon to Adelaide Hospital), and F. Conway Dwyer (Surgeon to Jervis Street Hospital). The annual general meeting of the Fellows, to consider the report of the Council for the past year, will be held on Saturday, June 3rd. The financial statement shows a falling-off of income (to April 5th) of £149, but a more than equivalent reduction of expenditure by £165. Since that date a large accession of income has accrued, mainly from Fellow-

ship fees, so that the college stands now, for the first time since it reconstructed its school in 1889—not only free of the debt of £8,000, which that process entailed, but with over £544 to its credit. For this meeting of the college the following notices of motion have been tabled and, no doubt, will be discussed:—By Deputy-Surgeon-General C. Kilkelly:—That it be recommended to the Fellows: “That canvassing by candidates for the offices of president, vice-president, and members of council of the college be in future strictly prohibited.” By Messrs. H. FitzGibbon and R. B. M'Causland:—“That it be recommended to the Fellows: “That a clause be inserted in the declaration on the envelope for voting papers to the effect that the Fellow voting has not deputed any other Fellow to mark his paper for him, or given authority to anyone to act as proxy for him in so doing, or signed his declaration previous to his paper being marked by himself personally.”

An unprecedented and most regrettable incident has occurred in connection with the Presidential election. Up to the 21st inst. there seemed to be nothing to disturb the even tenour of the election, and harmony reigned as far as was consistent with a contest. On that day, however, Mr. Fitzgibbon, one of the Councillors, and an ex-President, issued to all the Fellows a circular note, which, of itself, was extraordinary, inasmuch as it was marked “Strictly private,” although it had been sent to about 300 Fellows; was dated from the College of Surgeons instead of from his own residence, thus *pro tanto* making the College responsible for the pronouncement; and, furthermore, set forth an extract from the Minute Book of the College Council, which, from time immemorial, has been treated as not for publication under any circumstances. These little peculiarities of the circular were nothing remarkable as compared with its contents. It announced Mr. Fitzgibbon's candidature for the Presidency, as against Mr. Myles, and gave as his reason the statement that the latter gentleman had associated himself with the United Irish League and with Mr. Egan, who recently refused to hand to Her Majesty, as sword-bearer, the sword of the City of Dublin, and with Miss Maud Gonne, well known as the political fury of the extremest National party. The fact was that Mr. Myles had done nothing more than accept the freedom of the city of Limerick, of which he and his family were natives and residents, and he knew nothing of the United Irish League or its belongings. Mr. Fitzgibbon had, in fact, made himself responsible for a letter which appeared in the *Evening Telegraph*, of December 2nd, 1899, from our “Own Correspondent,” which gave an account of a meeting of that League. His mistake was at once pointed out through the agreeable medium of a Writ in damages, from Mr. Myles's solicitors, and he hastened to correct the error, which he did by the publication in many of the papers of an ample apology dictated by them, and everyone hoped that the storm had blown over until, on Saturday last, a further letter

from Mr. Fitzgibbon's pen, which we publish to-day, appeared in the newspapers. It is reported that Mr. Myles's legal advisers are of opinion that this letter is equivalent to a withdrawal of the apology, and that it is open to Mr. Myles to proceed with his action for damages if he pleases, but we know neither the facts nor the law of the case, nor are we at all concerned save for the prestige of the College of Surgeons. In this connection we cannot do less than express our deep regret that Mr. Fitzgibbon should have, for the first time in the history of the College, introduced, in the most rancorous form, the political venom which is the bane of all public life in Ireland. The intimates of Mr. Myles and Mr. Fitzgibbon have known for years past that they are diametrically opposed in political sentiment, and no one has a right to restrict their expression of opinion by their votes outside the College or even by the private exercise of the collegiate suffrage in the ballot, but, in our opinion, no Fellow has a right to import into the arena of collegiate affairs any consideration whatever save the business of the institution and its interests, and we trust that, should any attempt be made in future to do so, the Fellows will promptly show their disapproval.

THE GOVERNMENT OF THE BRITISH MEDICAL ASSOCIATION.

IN these modern days it is the manner of things to move quickly, even in the medical world, which in many ways may be regarded as one of the most conservative sections of the community. It is therefore necessary to note with some care the signs of the times, however seemingly trivial and unimportant, for it becomes more and more difficult for the skilled observer of current events to say whither they portend. For years past the constitutional government of the British Medical Association has been assailed, and on one occasion at least there has been a considerable secession of leading members over a question of policy. Last year at Portsmouth a resolution was passed which virtually affirms the right of members of the Association to make their own laws, for that is connoted in the adoption of the principle that the Council are bound to carry into effect the resolutions passed at general meetings. No reasonable persons acquainted with the facts of the case will deny that sufficient ground existed to warrant such a contention. Year after year important matters are discussed, and definite measures agreed upon, but year after year those resolutions remain a dead letter recorded in the transactions of the Association. That such a state of affairs should exist in an active body is intolerable, and it is little wonder that the hand of the reformer is being steadily turned in that direction. It is hardly necessary to remind readers that medical men are accustomed to the autocratic and irresponsible government of societies and corporations. The British Medical Association and the defence societies have a sound democratic basis, and in the case of the Association there has never been any serious attempt to place the control of that body

in the hands of a knot of wirepullers. At the same time there seems to be little question that the future welfare of the Association demands a readjustment of its representative government. That view was ably advanced by Dr. Garrett Horder at the recent conference at Manchester on medical organisation. He dealt with the British Medical Association from a general practitioner's point of view, and points of considerable interest were raised both in his paper and in the subsequent discussion. It is only with his views upon the constitution of the Council only that we propose to consider here. His main criticism appears to have hinged on the fact that an undue proportion of the councillors are elected from the ranks of the consultants. There is a good deal of force in the contention that such men are not likely to be enthusiastic in advancing reforms that concern chiefly or wholly the main mass of practitioners. The obvious remedy is for the local branches to elect as councillors men who are in favour of popular reforms. For that purpose members of the Association will have to become also affiliated to local branches, and to become effectual will have to be assiduous in the exercise of their franchise. A good suggestion made by one speaker was that proxy votes should be accepted, a boon that would be greatly appreciated by members engaged in busy practice. Another important point is the redistribution of branches. The Association has long outgrown its early electoral divisions, with the result that in not a few instances particular districts are either grossly over-represented, or ridiculously under-represented. London has special cause for complaint in the latter direction, because of the utter and total inadequacy of its branches in point of number. Then there is a further weighty proposal in favour of the limitation of office of Councillor to a certain fixed period. Whether these proposals be ultimately adopted or not it is certainly to the advantage of the medical profession that they should have best possible discussion. It may be somewhat surprising to those who are acquainted with the methods of procedure at the annual meetings of the Association to note that no proposal was made as to the alteration of the present inconvenient arrangement. As matters stand, the general meeting, which settles matters of vital importance to members, is held sandwiched into the middle of a busy day, when most of those who attend have had their energies already taxed by hours of close attention to other things, and who have to look forward to further demands upon their endurance at a later period of the day. The fact is, that the President's speech and the other chief addresses should be held as delivered, and the church ceremony held on the Sunday previous to the gathering. The first two days might well be devoted to the discussion of matters such as self-defence, organisation, medical aid, the midwives bill, and other things that go right down to the root of everyday professional life. In this way a kind of medical parliament would be con-

stituted, and a weighty consensus of opinion would be forthcoming upon many matters in which the public is concerned. At present it cannot be said that the British Medical Association makes the most of its magnificent organisation so far as the wider and deeper material interests of the medical profession are concerned.

Notes on Current Topics.

Our Universities and General Practice.

THE question raised in the letter of a correspondent in another column, on the value of university education for those intending to enter the medical profession, is of some importance and interest. If those "just completing their career at the University" are really qualified as well as "anxious . . . to enter upon various departments of practical life," as stated in Mr. Archbold's letter in our last week's issue, the University of Cambridge may be regarded as an excellent place for medical students. When hospital life is finished, and qualification to practice is first obtained, we doubt much whether those who offer themselves as assistants are capable of discharging their duties properly; for all that was learnt in old apprentice times is not now obtained by those who have only studied at hospitals. We should like to hear from Mr. Archbold what provisions are made at Cambridge for the education of students, so that they are ready to go as assistants at home or abroad. Passing examinations for the M.B. may not be quite the best test of a student being fitted to act as an assistant. A certain amount of value is attached to the degree obtained at a University, and it is not unnatural that students should feel a pride in possessing it, especially as certain social advantages accrue to the holder. It is well, however, to appreciate fully the kind of education that ought to be followed by those who intend to act as assistants. If the University of Cambridge really prepares its students for this life, it must have changed greatly from what it was some years ago. There is no doubt but that country practitioners find it difficult to obtain assistants qualified for the various duties required of them unless some time has been spent after leaving the hospital in actual practice. In olden days a good deal was learnt by allowing students to help in the surgery thus learning what they could not acquire in hospitals. It is very doubtful now whether a student who has just passed the qualifying examination is fitted "to enter upon various departments of practical life as assistant," &c. It is a common complaint amongst country practitioners that they cannot find assistants willing and able to discharge their duties; and certainly University men of some years ago were the least fitted for, and quite disinclined to take posts of this nature. Many parents will be delighted to send their sons to Cambridge if things are so changed that students are prepared and qualified to act as assistants when they have completed their studies.

Allinson as Infant Feeder.

By some comic opera sort of contrivance the General Medical Council is pithed of any real authority in the control of "infamous" practice. That estimable body may solemnly excommunicate an offender by bell, book and candle, and erase his name from the *Register*, but after all said and done he may, and usually does, continue in active, albeit unqualified, professional practice. An instance of this kind was brought to light last week by means of an inquest at Walthamstow held upon the body of an infant of 20 months. The mother, who was the wife of a gasfitter, said she would not go to "drug" doctors, but preferred to have "hygienic" doctors. She fed deceased on Allinson's food, and took it to "Dr." Allinson, 4, Spanish Place, Manchester Sq., when she seemed unwell. The evidence of the divisional surgeon was to the effect that deceased weighed 9 lbs. instead of 26 lbs., which would have been the proper weight, and that farinaceous food was most improper for a child of that age. T.R. Allinson appeared in person, and stated that he was qualified in 1878, and that his food was composed principally of pearl barley. The jury returned a verdict of "death from improper feeding," to which they appended the following expression of opinion:—"The Jury consider that the parents are much to blame in not having had proper medical advice for the deceased, and that 'Dr.' Allinson is also to blame in undertaking the care of the child from such a long distance, and they desire to call the attention of the National Society for the Prevention of Cruelty to Children to the case." It would be well for future juries under similar circumstances to call the attention of the public and of the General Medical Council to the scandal that permits the lives of her Majesty's subjects to be at the mercy of men who have been disqualified for infamous practices.

Mediæval Sanitation in West Suffolk.

SUFFOLK has long since earned the epithet of "sleepy," and it seems possible that the key to its lethargy may be found in the bad sanitary conditions that prevail among the dwellings of the poor in that county. The powers that be in West Suffolk have recently decided not to elect a District Medical Officer of Health, but to leave things as heretofore, under the control of a County Medical Officer. From a long experience of the latter species of administration we have little hesitation in saying that it is one of the least satisfactory methods with which we are acquainted in public health work. When the question was discussed at the West Suffolk Council one of the members, Sir Cuthbert Quilter, expressed his views with the utmost candour and clearness. He pointed out that the County Medical Officers found their principal patients among the members of District Councils and the owners of land, against whom they would have to bring adverse reports in the course of their duty. That position has been plain long ago to candid men acquainted with the facts of the case. The present

state of the cottage property in many rural districts of the United Kingdom is nothing less than a slur upon our boasted twentieth century humanity and civilisation. Nor is it likely that any considerable reform will be effected in that direction until independent medical officers are appointed to districts, or, what is in our opinion a far better plan, until well-paid whole time officers are given life appointments in counties. As a rule the half-pay county medical officer of health is an anomaly, a costly anachronism, a dummy official whose only chance of keeping in office is to refrain from interfering with the property of the landlords who are his masters. By all means let us have security of tenure, whole-time duties and adequate salary for county medical officers of health.

"Punch" on Counter-Prescribing.

OUR old friend and contemporary, *Punch*, has his occasional good-humoured fling at medical men, but his cartoon of last week contains a profound and unintentional satire on the dangerous practice of counter-prescribing. Mr. Tenniel has drawn with graphic pencil a kangaroo coming to the Imperial Dispensary and presenting a prescription to Mr. Chamberlain, who figures as the chemist. The latter replies: "Of course, I *could* make it up for you, but I think I can give you something that will exactly suit your constitution." The truth of the picture will be universally recognised. The man in the street regards the average chemist as an authority on medical matters, whereas, of course, his function is merely to make up and dispense remedies ordered by properly qualified medical practitioners. There can be no doubt that the aggregate amount of counter-prescribing that goes on in the United Kingdom is simply enormous. It is terrible to reflect upon the deadly mischief that must result, for the accurate estimate of disease and its treatment can be acquired only as the result of long training and of conscientious investigation. There is a great amount of truth in the proverb that every man who acts as his own lawyer has a fool for a client. A similar assertion could be made with far more emphasis when a layman acts as his own physician, or deliberately entrusts his ailments to the care of an unqualified practitioner, for the prescribing chemist comes under that description. It is to be hoped that friend *Punch* will do some amount of good by his cartoon of the confiding kangaroo and the prescribing chemist who wished to better the prescription of a qualified medical man.

The Liverpool School of Tropical Diseases.

THE importance of a full knowledge of tropical diseases is self-evident in the case of a vast empire like that of the United Kingdom. The rapid advance of bacteriology has placed the study of infectious disease upon a sound and tangible basis, so that to the modern scientific medical investigator the unravelling of the inner secrets of all tropical infections is simply a matter of time. The work of the special schools founded of recent years for the study of tropical diseases has therefore been watched with

considerable interest by the medical profession both at home and abroad. Among such institutions the Liverpool School of Tropical Diseases has maintained a front rank position by dint of unceasing energy. Within the last nine months it has despatched two expeditions to foreign countries to conduct special inquiries. A third is to follow shortly with the view of investigating yellow fever on the Amazon. It is hardly necessary to remind readers that this terrible disease is endemic in the West Indies, in Brazil, and in certain parts of West Africa. In 1890, Sternberg made a full research into the bacteriology of the disease and isolated an organism which he named "bacillus x," apparently connected with the origin of the disease. In 1897, Sanarelli obtained cultures of a microbe which he called "bacillus icteroides," apparently identical with Sternberg's micro-organism. This special fungus belongs to the bacillus coli communis group, and horses have been successfully immunised against its invasion. It is to be hoped that the Liverpool School of Medicine will gain fresh laurels by finding out how to prevent this most terrible scourge of mankind.

Treatment of Fractures.

JUDGING from the numerous articles and lectures which are appearing in the medical press on the treatment of fractures, it will occur to the minds of not a few that when the use of the X-ray method of photography came into vogue the forecast then made, that the treatment of fractures would be greatly influenced, appears to be at the present time in course of fulfilment. Mr. Golding-Bird, in a communication recently published, expresses his opinion that to operate in the case of a fracture in order to obtain an absolute linear adaptation of the shin bone that will stand the test of a skiagraph is not in his opinion justifiable; he further sounds a note of warning against appealing to skiagraphy in surgical work as proof of the good result of treatment. In an article by Dr. G. Davis, of Philadelphia, in the *Therapeutic Gazette* of May 15th, he very truly says that the progress which surgery has made in recent years has much disturbed the orthodox teachings of the past, and also asserts that an operative case heals in the same time as does a simple fracture in good position, the best possible result being obtained. The question of operation, he adds, is to be decided by one's ability to get the fragments in proper apposition. Mr. Arbuthnot Lane, lecturing at Guy's Hospital on Friday last, explained in detail the operative treatment of simple fractures, and stated the case in a very few words when he remarked that the surgeon must not be content with what is called clinically "good position" when a perfect result can be attained by operative procedure; and this clearly is of great importance in the case of the leg. At the conclusion of his lecture he said that those who continue to assert that they are able to restore broken bones to their original form by the orthodox procedures, can readily substantiate the truth of their statements at the present time by means of the radiograph, and if they have

any confidence in them will doubtless do so. Compensation cases in courts of law will sooner or later force the whole question of the treatment of fractures to a clearer issue than is now the case.

Hospital Wards on Show.

THE authorities of Charing Cross Hospital have fitted up and opened a model ward in the Exhibition grounds at Earl's Court. The ward is modelled from the wing now being erected in connection with the special appeal fund on behalf of the hospital. Here will be seen the most modern surgical instruments, and many ingenious appliances for the comfort of the sick. "It may be mentioned," says the *Daily Telegraph*, "that many of the exhibits on view are the invention of members of the profession, and there is present at Earl's Court a staff of nurses who will be found very willing to give the visitor information on any point of interest." This principle is evidently capable of extension. If Charing Cross can run a model ward at Earl's Court, why should not Westminster have a model of its operating theatre at the Hippodrome, or St. Thomas's of its bacteriological laboratory at the London Pavilion? Real nurses in fancy costumes could be engaged, and on special nights they might give demonstrations on the mode of preparing poultices or on the administration of enemata. The idea might be extended indefinitely, and the funds of the hospital would benefit—temporarily, at all events. What the effect would be on the reputation of our charitable institutions would be ultimately a quite another matter. It is to be hoped that the statement about Charing Cross is devoid of foundation. If true, the members of the hospital staff will have to consider their position, for this form of advertising is not palatable and is not reputable, however pre-alluring it might prove to matrimonially-inclined nurses. Some years ago the London Hospital set this undesirable fashion by sending a tracheotomy cot, with a wax figure of a baby having the tracheotomy tube *in situ*. This shocking outrage on good taste was seriously upheld at the time by lay members of the hospital management.

Horse Sickness at the Cape.

ONE of the great difficulties in the path of the British Army during the present South African campaign has been the wholesale destruction of horses by sickness. The epidemic that works the mischief rages during the summer months and disappears before the first touch of frost. There is reasonable ground for assuming, therefore, that the disease is due to a specific infection, although, so far as we know, its special bacteriology has not yet been investigated. One peculiarity is that in many instances the head and neck of the affected animal swells to an enormous size, doubtless due to lymphatic invasion by the microbes that cause the malady. In this particular one is reminded forcibly of the grotesquely enlarged head and neck often seen in swine affected with anthrax. Treatment of the disease is at present hopeless, but there is every probability that when the disease-producing micro-

organism is captured that its antidote will speedily be forthcoming in the scientific laboratories devoted to studies of the kind. The economic importance of such a discovery both to the present and to the future prosperity of South Africa would be well-nigh incalculable. Meanwhile there is a wide field of conquest awaiting some young and ardent bacteriologist—who need not go to the Cape to prosecute his inquiries. All he wants is some of the blood and tissues of an infected animal sent by mail to the mother country. Here is a good opening for the School of Tropical Diseases. We would suggest that Government offer a handsome prize—say two thousand pounds—to the discoverer of the bacterium of horse sickness in South Africa.

Poisoning by Honey.

THE literature of honey-poisoning is tolerably voluminous, and the subject is of some practical interest. Voorhees, in the *Therapeutic Gazette*, refers to the case of a man, æt. 54, who ate 4 ozs. of fresh honey. Soon after he felt a sensation of burning in his forehead. He suffered from hallucinations, shivering fits, and finally rigors. The heart's action became feeble and irregular, the respirations difficult, rough, and slow. Convulsions commenced in one arm, and gradually extended to the whole body. An emetic and stimulants were administered, and the patient finally recovered; but mydriasis, pricking of the tongue, and marked weakness persisted for a long time. The honey is reported to have had a bitter taste. Xenophon reports that some of his soldiers suffered from vomiting, pains and delirium after eating honey. Barton, in 1799, recorded similar cases in Florida, Pennsylvania, and elsewhere. Haseman (*Traité de J.*) relates that in Altdorf Switzerland, two deaths occurred from eating honey, and Jenner observed grave accidents follow the use of honey (*Ther. Gaz.*) The toxic effects are attributed to the flowers on which the bees fed. Hasemann ascribes his own cases to the *Azalea pontica*, and to the *Rhododendrum ponticum*, which, according to Plügge, contains a very active poison, which also exists in many *Ericaceæ*s, and which was encountered for the first time in the *Andromeda Japonica*, hence the name Andromedotoxina. Barton accuses the *Calmia angustifolia*, which is found to contain the andromedotoxina (Plügge). Jewett blamed the foxglove, and Haseman the monkshood. Dr. Neale, in section 486, sub-division 5, of his Medical Digest, notes some cases, and THE MEDICAL PRESS AND CIRCULAR on page 270 of the second volume for 1896 reports an interesting case of the kind. Kebler (*Am. Jour. Ph.*) reports in 1896 a case of poisoning by honey in which the symptoms were vomiting, purging, and acute gastric and abdominal pain, followed by loss of consciousness, coldness of extremities, feeble action of the heart, and almost collapse. Recovery did not take place for some hours. The effects were attributed to andromedotoxin, emanating from the plants of the order *Ericaceæ*. But the presence of the poisonous principle could not be definitely established. The Brazilian

wasp is credited with producing a poisonous variety of honey, irrespective of what flower it feeds on.

The Army, Navy, and Indian Competitives.

WE again call the attention of the Irish licensing bodies and teachers to the returns of the Army, Naval, and Indian Medical Competitives for February, 1900, as presented to the General Medical Council last week. For the Army service 17 vacancies were given away. There was, in fact, no competition, there being 30 vacant places, and every man who presented himself was taken into the service. Ten out of the 17 were Irish. For the Naval examination of the same date 20 candidates were taken in but of these only two were Irish, both from the Universities, and not a single man from the College schools. For the Indian service there were 18 vacancies, four of which were won by the Irish contingent; but here again there was but one success to the Dublin collegiate schools. It appears that such figures, frequently repeated as they have been, establish the fact either that the examinations are grossly partisan, and that Irish candidates are habitually boycotted by the London examiners, or else that the school teaching of Dublin is grossly incompetent. We leave the choice of these alternatives to the Irish teachers.

Chorea and Menstruation.

DR. GENTIAN in the *Archivos Ginecopatia*, adduces some interesting facts in support of the influence of menstruation on chorea. He gives the following statistics showing the ages of the patients at the onset of the symptoms of chorea:—From 5 to 10 years, 18 cases; from 10 to 16 years, 45 cases; from 16 to 20 years, 13 cases. He found that when the menses appeared the chorea ceased; when, however, the flow was insufficient in amount or deficient in colour the function had no influence on the disease. That women during pregnancy are subject to chorea is universally recognised; from the clinic of Baudeloque, from 1889 to 1899, the author finds there were 15 cases of chorea out of the 15,638 deliveries; one in every 1,042 cases. Of these ten occurred in primipara. Of the 15,638 mothers 89 had had chorea as children, of these 15 had a severe form of the malady. He concludes that children who suffer severely from the disease prior to their menstrual period are liable to be attacked with the disease during their pregnancy. The treatment recommended for children and adults is chloral in full doses; during pregnancy the patient is to be put on a milk diet.

Visits of Policy or Supererogation.

A MEMBER of the medical profession, who was proved at the present Session of the General Medical Council to have employed an unqualified assistant, explained the position occupied by the assistant as that only of a "pupil," and on being pressed, in cross-examination, to enumerate the duties performed by his "pupil," mentioned, among others, that of making visits of policy or supererogation, which somewhat curious employment

seemed to include that of issuing certificates to enable members of the clubs to enjoy a few days' rest when afflicted with trifling ailments. The "pupil" also attended midwifery cases apparently under some supervision, and by the aid of the telephone the assistant was able to consult with his employer two miles off in the diagnosis of cases; but the medical practitioner concerned denied that he had the help of a telescope at the end of his telephonic installation for the purpose of carrying out this up-to-date method of instructing "pupils" in medical knowledge.

Medical Affairs in Parliament.

WITHIN the last fortnight the progress of measures in which the profession is interested has been backwards. The Midwives Bill is relegated to June 27th, when the report of the Grand Committee on law may possibly be discussed. It is vigorously opposed and, as on that day the debate must close at 5.30 p.m., its chances seem remote. A Bill for the purpose of extending the disciplinary powers of the College of Veterinary Surgeons got second reading on the 22nd, and it is awaiting consideration by the Grand Law Committee. A Select Committee has been appointed to consider whether hospitals and other such like institutions should be relieved—wholly or partly—of the payment of rates. Dr. Farquharson, Mr. T. W. Russell, and Sir Cameron Gull are members of the Committee. The Plumbers Registration Bill—a measure to secure the monopoly of soldering a gaspipe to the nominees of the Plumbers' Guild—and the Architects' Registration Bill—a much more deserving measure—also received their quietus for this session.

The Official Definition of Wounds.

As medical men are often appealed to as to the meaning of the official descriptions applied to the wounded in South Africa, the following notice issued by the War Office is of practical interest:—"Slight."—A wound likely to heal rapidly, not impairing the use of a limb or organ, and often not even entailing admission into hospital. "Severe."—A wound requiring careful treatment in hospital, but not necessarily dangerous, often involving fractures of bone, and sometimes even the permanent impairment of a limb. "Dangerous."—A wound such as might occur from the penetration of the head, chest, abdomen, or any vital organ. In many cases, however, it is hardly needful to add that soldiers reported dangerously wounded have recovered. The percentage of deaths from wounds of all sorts among those admitted to hospital has, during the present campaign, reached only 5 per cent. on the total wounded.

The International Medical Congress.

THE Paris Executive of this Congress give notice that the final prospectus is about to be issued. This prospectus will contain the titles of all communications with the names of the authors which have been sent to the sectional secretaries in Paris before June 15th next. It is necessary therefore that all notices should be sent to Paris at once. The list of members

will be closed on July 15th, and communications can be made until that date, but such belated notices will not appear in the final prospectus. The British Government has officially appointed the following gentlemen to represent Great Britain and Ireland at the forthcoming Congress: (1) Lieut.-Col. E. F. Drake-Brockman, I.M.S., delegate from the Indian Medical Service (Great Britain). (2) Brigade-Surgeon Lieut.-Col. Alexander Crombie I.M.S., delegate from the Indian Medical Service (Great Britain). (3) Fleet-Surgeon Gilbert Kirker, M.D., R.N., representing the Naval Medical Service. (4) Mr. Thomas Joseph Stafford, F.R.C.S.I., Medical Commissioner of the Local Government Board, Ireland. These appear to be the only delegates of which the general committee at Paris have official cognisance.

Sir John William Moore.

THE distinction conferred on the occasion of Her Majesty's birthday upon Dr. John William Moore, President of the Royal College of Physicians in Ireland, will be a most popular one. The recipient was born in 1845, and was the eldest son of Dr. William Moore, one of the most cultured practitioners and most expert linguists in Ireland. Having received his primary education in Dublin, Sir J. W. Moore passed through the University, obtaining the high distinction of a scholar of the house, besides the highest degrees in arts, medicine, surgery, and state medicine. He is at present senior physician to the Meath Hospital and Professor of Medicine in the Royal College of Surgeons, besides being consultant to other hospitals too numerous to mention. He is a notable authority on meteorology and on sanitation, his "Manual of Public Health" being a sound *vade mecum* for all sanitarians. He has also acted as editor of the *Dublin Journal of Medical Science* ever since 1873. We are convinced that there is scarcely a member of our profession in Ireland who would not heartily join in the congratulations which we now offer to him on his well-merited distinction.

The Pay of Civilian Medical Officers.

WE learn from an authoritative source that the Secretary for War has approved of pay at the rate of £1 per day being given to civilian medical practitioners in temporary military employ, who are not receiving either fixed or capitation rates of pay from Army funds. This decision will clear the ground of many of the uncertainties existing since the absence of so many Army medical officers in South Africa necessitated the employment of civilians for home service.

THE Leeds Board of Guardians are to be congratulated on their proposed liberality to the medical officer, notice having been given that at the next meeting it will be moved that the salary of Mr. Allan, chief medical officer at the workhouse, be raised from £400 to £500 per annum.

THE verdict of the coroner's jury at Tredegar, Wales last week, on the body of Dr. W. S. Thomson—

"Death resulting from an overdose of opium whilst in a state of intoxication"—is a sad comment on nineteenth century ideals. Deceased was only forty-five years of age.

PERSONAL.

DR. BUZZARD has been elected a member of the Council of King's College, London.

THE Earl of Rosebery has been elected President of the Royal Medical Benevolent College.

PROFESSOR E. KLEBS has resigned the teaching appointments which he has held for some years in Chicago, and intends to return to Germany.

WE much regret to learn that Dr. Cranny, of Jervis Street Hospital, Dublin, has been seriously ill for the last ten days. He was reported on Sunday last to be better.

THEIR Royal Highnesses the Duke and Duchess of York have promised to open the new infirmary at Highgate, which has cost the large sum of £200,000, on July 16th.

MR. C. H. GOLDING-BIRD has added his name to the list of candidates for a seat on the Council of the Royal College of Surgeons of England. Mr. H. H. Clutton will also seek election.

SIR JOHN BURDON-SANDERSON, Bart., M.D., F.R.S., Regius Professor of Medicine in the University of Oxford, had the honour of presentation to H.R.H. the Prince of Wales at the Levée on Monday last.

SIR E. H. SIEVEKING has been elected Vice-President of the Royal Medical Benevolent College on his retirement from the Council. Sir Edward was the first honorary secretary, a post which he first occupied now some fifty years ago.

THE residents of Brinton, Devonshire, and surrounding districts, have presented Mr. S. Orson Lane, M.R.C.S., L.S.A., with an illuminated address and a purse containing 120 sovereigns, as a mark of respect and esteem on his retirement from practice.

DR. CHURCH, President of the Royal College of Physicians, London, gave two official receptions at his private house in Harley Street on Tuesday and Wednesday last. There was a large attendance, including many members of the General Medical Council now sitting in London.

DR. EDWARD JOHNSTON QUINLAN, who died last week at his residence in Dublin, was formerly Examiner and Councillor in the Royal College of Surgeons. For very many years up to the sixties he served the Irish Medical Association as its Honorary Secretary, and always took much interest in, and devoted much labour to, its work.

IT is of interest to note that the Professorship of Medicine in the University of Edinburgh was bestowed on a gentleman who sent in no testimonials whatever. The practice of sending in a shoal of testimonials has grown to such an extent that it has been not unusual for a candidate to issue several gilt-edged volumes of that particularly depressing kind of literature. It is to be hoped that recent events will bring about an alteration in this particular. Possibly some of the volumes may be of service in the forthcoming election of a Professor of Medicine in the sister University of Glasgow.

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

PROFESSIONAL SECRECY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—If your correspondent signed "Conscience" will kindly refer to my letter of May 16th he will find he has misquoted me. He states, "I am informed Mr. Sers is in error in supposing that 'no secrecy' exists between lawyers and their clients in the sense referred to."

On the contrary what I stated was that the same secrecy existed between a solicitor and his client as between a medical man and his patient. I naturally infer from this that we have no *locus standi* in law to suppress evidence from a court other than solicitors.

I apprehend, however, that a medical man, like a solicitor, could appeal to a judge as to the necessity of answering any given question, and hence their claims with regard to professional secrecy appear to me to run parallel.

As to the first part of your correspondent's letter respecting my having missed the point—viz., that we are striving to establish a prerogative in our favour with regard to what I may call especial professional secrecy—I venture to prophesy any efforts in this direction would prove futile, as the course of justice would thereby be impeded.

If I may be allowed to offer "Conscience" a hypothetical instance, let us suppose him (assuming, of course, that he is a medical man) attending a patient who committed suicide, the patient confessing to him such act, and the inquest being held in due course. Does "Conscience" suppose that the Legislature would pass an enactment whereby he could suppress the truth on the ground of "professional secrecy"?

The same doctrine applies to a Divorce or other Court, and the idea of medical men holding secrets in the presence of a law-court I submit is purely ideal and impracticable.—I am, Sir, yours truly,

CLEMENT H. SERS.

Queen's Road, S.E., May 24, 1900.

CAMBRIDGE APPOINTMENTS ASSOCIATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It would interest some of the old Cambridge men, and probably other members of the profession, if Mr. Archbold would give more information respecting the Cambridge Appointments Association. It is not very clear from Mr. Archbold's letter what are the qualifications of those who are just completing their career at the University (Cambridge); and are anxious to enter "as assistants, &c., both in England and abroad." A University career has certain advantages, but whether it qualifies for the work of an assistant requires demonstration. That kind of knowledge and training which fits a young man to be a good assistant used certainly not to be obtained at Cambridge some years ago. It is doubtful whether the life of a country assistant would be at all agreeable to a Cambridge graduate, and we cannot expect practitioners to take as an assistant one who comes to him to learn rather than to assist. If Mr. Archbold is really in a position to provide well-qualified assistants who have gone through a University training, it will be well for the Association to make itself known.

It is a question of some interest at the present time to those whose sons are entering the profession, that is, are beginning their studies, whether there is any advantage in sending them to a University; as in old times the education provided at Cambridge was really not good for those looking forward to general practice. It is injurious to a young man to give him the idea that a University degree makes him superior to those who have been trained in a very different way, that is, more or less on the old fashioned principles of apprenticeship. The question of capital must be considered, and if parents have to economise in order to send a son to a University, it is only when the boy has superior qualities which will enable him to obtain some of the rewards

of University life, and to repay his parents, that it is wise of them to place him in such a position.

I am, Sir, yours truly,

INQUIRER,

THE PRESIDENCY OF THE ROYAL COLLEGE OF SURGEONS, IRELAND.

MYLES V. FITZGIBBON.

To the Editor.

Dear Sir,—I shall be obliged if you will publish in your next issue the apology, of which I enclose a copy, which Dr. Fitzgibbon to-day has tendered to Dr. Myles, and which Dr. Myles has accepted. The consent putting an end to the action will be made a rule of Court on the first day a Judge or Court of the Queen's Bench sits.

Faithfully yours,

JOHN WALKER

(Solicitor for the Plaintiff).

(Copy of Apology).

49, Merrion Square, Dublin,

24th May, 1900.

Dear Sir,—I regret the publication and circulation of the two circulars and the reprint from the "Evening Telegraph" newspaper which I sent to the Fellows of the Royal College of Surgeons (Ireland) in connection with the election to the office of President. I admit there was no justification whatever for associating you with the names or organisations mentioned or referred to in the said circulars and prints and I unreservedly withdraw all suggestions and imputations against you therein contained, and I apologise, therefor.

I have also this day withdrawn from the candidature for the Presidency of the College. I admit that my action left you no option but to commence legal proceedings, and to take the other steps you did to put the true facts before the Fellows of the College and the public, and I undertake to indemnify you against all costs and expenses of every kind which you have been put to since the issue of my circulars, including the cost of publication in such papers as you select for this apology, and the making of a consent to stay your action on the terms contained herein a rule of Court.—Yours faithfully,

HENRY FITZGIBBON, M.D.

Thomas Myles, Esq., M.D., Vice-President Royal College of Surgeons (Ireland).

SIR,—In consequence of Mr. Myles' refusal to allow me to embody in my letter of apology, dated the 24th inst., and published in the Dublin press of this date, my explanation as to how I fell into the serious mistake as to a matter of fact appearing in the circulars addressed by me to the Fellows of the Royal College of Surgeons in Ireland, it becomes necessary for me now to publish my explanation through the medium of the press.

The mistake referred to arose from the publication of Mr. Myles' acceptance of the offer of the freedom of the City of Limerick having appeared in the "Evening Telegraph" immediately in succession to the report of the meeting of the United Irish League, and being assumed by me to have been part of the proceedings at that meeting.

I was not aware of my mistake until I read in the Dublin evening papers of the 23rd inst. the report of the motion for an injunction, in which paragraphs from an affidavit made by Mr. Myles were quoted. As soon as I became aware of the error into which I had fallen I tendered, through my solicitors, to the legal adviser of Mr. Myles a complete apology.—Yours truly,

HENRY FITZGIBBON, M.D.

49, Merrion Square, May 25th, 1900.

PASS LISTS.

Royal College of Surgeons in Ireland.

FELLOWSHIP EXAMINATION.

The following candidates having passed the necessary examination have been admitted Fellows of the College:—

Mr. J. H. Conway, Mr. F. C. Crawley, Miss S. Gray, Mr. K. L. G. Gunn, Mr. S. H. Law, Mr. M. J. Madden, M. J. F. Mannix, Mr. L. R. Mure-O'Ferrall, Mr. M. O'Sullivan, and Mr. W. G. T. Posnett.

Notices to Correspondents, Short Letters, &c.

✂ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

THE TREATMENT OF ALOPECIA AREATA.

To the Editor of THE MEDICAL PRESS and CIRCULAR.

SIR,—In answer to your correspondent "Practitioner," I beg to inform him that spirits of soap consists of equal parts of soft soap and spirits of wine. By "musicians' length of hair," I intended to convey the idea that the hair should be cut about 3 ins. from the scalp. I admit the vagueness of the phraseology. I borrowed the term from the French.

I am, Sir, yours truly,

TOM ROBINSON.

9, Prince's Street, Cavendish Square, W.,
May 24th, 1900.

DR. ASHMEAD (New York).—We hope to have space for your communication in our next.

"ST. SIMON."—The water about which you inquire is well-known at Aix-les-Bains, where you see it on all the hotel tables. We do not know if there is any depot for it in London; but as you are going to the Paris Exhibition you will certainly find it there, and you can then get all information. It is from the Bapby Spring at Aix-St. Simon, a suburb of Aix-les-Bains. This water is alkaline-magnesian, pleasant to drink, and is well recommended for gastric troubles; and as "lessening the formation of uric acid in gouty and rheumatic complications." Some prefer it to the better-known waters of Vittel and Evian. (See article "Aix-les-Bains," MEDICAL PRESS and CIRCULAR of July 12th, 1899.)

EXPENSIVE CUCUMBERS!

SMITH: "I saw you carrying home a couple of nice-looking cucumbers last night, Brown; how much did they cost you?"

Brown: "I don't know yet. The doctor is up at the house now."

DR. McDERMOTT AND MR. SWANN.—The letters of our correspondents are unavoidably crowded out of the present number.

ROXTON RAY.—You will find a brief reference to the Demonstration under the heading of "Meeting of Societies." We have been favoured by Dr. Macintyre with full notes of the paper in question, for which we hope to have space in our next or following week.

MR. W. E. R.—We have made inquiries, and find that the reason why the book is not now obtainable is because of its withdrawal some months since to be remodelled.

DR. LEIGH S.—We advise you to wait until the matter has been definitely settled by the Italian Government.

Meetings of the Societies and Lectures.

WEDNESDAY, MAY 30th.

BRITISH BALNEOLOGICAL AND CLIMATOLOGICAL SOCIETY (20, Hanover Square, W.).—6 p.m. Ordinary meeting. Election of Officers and Council for the Session commencing October, 1900, at General Meeting following. 7 p.m. Annual Dinner at Limmer's Hotel, Conduit Street, W. 9 p.m. Annual Conversazione at 20, Hanover Square. Sir Joseph Fayrer, Bart.: The Hill Stations of India as Health Resorts.

FRIDAY, JUNE 1st.

WEST LONDON MEDICO-CHIRURGICAL SOCIETY (West London Hospital, Hammersmith, W.).—Clinical Meeting. Specimens and Cases:—Mr. G. Pernet: Sections of Leprous Nodules, showing the Macilli.—Mr. S. Paget: Case of Retroperitoneal Abscess.—Mr. Bidwell: Case of Arthrectomy of Elbow.—Mr. McAdam Eccles: Cases Illustrating Swellings upon Digits.—Dr. Ball and Dr. Abraham: A Case of Tuberculous Disease of the Skin and Mucous Membranes.

LARYNGOLOGICAL SOCIETY OF LONDON (20, Hanover Square, W.).—5 p.m. Cases and Specimens will be shown by Mr. Butlia, Mr. Lake, Mr. W. Downie, Mr. Lack, Mr. Parker, Mr. Steward, and Mr. Waggett.

Appointments.

DUNLOP, T. M.B., C.M. Edin., D.P.H. Cantab., Medical Officer of Health for the Aldershot Urban Sanitary District.
HARRIS, J. H., M.R.C.S., D.P.H. Cantab., Certifying Surgeon under the Factory Acts for the Dartmouth District.
HEMMANS, LAWRENCE, F. M.B., B.S. Durh., House Surgeon to the Great Yarmouth Hospital.
HODGKINS, A. E., L.R.C.P. Lond., M.R.C.S., Resident Medical Officer for the Children's Hospital, Birmingham.
LEFEVRE, G. L., M.B., C.M. Glasg., Medical Officer for the Longton Sanitary District for the parish of Stoke-upon-Trent.
McDOUGALL, J. E., M.B. Vict., M.R.C.S. Cantab., Honorary Assistant Laryngologist to the Stanley Hospital, Liverpool.
NEWMAN, GEO., M.D. Edin., D.P.H. Cantab., County Medical Officer of Health by the Bedfordshire County Council.
PLAYFAIR, HUGH, J. M., M.D., F.R.C.S., M.B.C.P., Obstetric Tutor to King's College Hospital, London.
PRESTON, C. H., M.D., B.S. Lond., L.R.C.S. Eng., Lecturer in Dental Anatomy and Physiology, Owen's College, Manchester.

PUGH, C. G., R.Sc. Lond., L.R.C.P., F.R.C.S., Assistant Medical Officer to the new Infirmary Bethnal Green

Vacancies.

Carlisle Dispensary.—House Surgeon. Salary £150 per annum, with apartments, not board. Apply to the Hon. Sec., 23, Lowther street, Carlisle.
Cumberland and Westmorland Asylum, Garlands, Carlisle.—Junior Assistant Medical Officer, unmarried. Salary £130 a year, rising to £150, with board, residence, &c.
Devonshire Hospital, Buxton, Derbyshire.—House Surgeon and Assistant House Surgeon for twelve months. Salary of House Surgeon £100 per annum. Assistant House Surgeon £50, with furnished apartments, board, and washing in both cases.
Gateshead Union.—Assistant Resident Medical Officer, for the Workhouse. Salary £150 per annum, with furnished apartments, rations, and washing. Applications to the Clerk of the Union, Prince Consort Road, Gateshead.
Great Northern Central Hospital, Holloway Road, London.—House Physician and Junior House Physician, both for six months. Salary of House Physician at the rate of £60 per annum, with board, lodging, and washing in the hospital. Salary of Junior House Physician at the rate of £30 per annum, and board, lodging, and washing in the hospital. (See advt.)
London County Asylum, Banstead, Sutton, Surrey.—Junior Assistant Medical Officer. Salary £150 per annum, with board, furnished apartments, and washing. Apply to the Clerk of the Asylums Committee, Office, 6, Waterloo Place, S.W.
Nottingham General Dispensary.—Assistant Resident Surgeon, unmarried. Salary £140 per annum, furnished apartments, washing, &c., but without board.
Pontefract General Dispensary and Infirmary.—Resident Medical Officer. Salary £150 per annum, with furnished rooms, fire, lights, and attendance.
Royal Berks Hospital, Reading.—House Surgeon. Salary £60 per annum, with board, lodging, and washing. Also Assistant House Surgeon. Salary £50 per annum, with board, lodging and washing. Both appointments for one year.
Royal City of Dublin Hospital.—Assistant Surgeon. Applications before June 9th to Mr. G. Jameson Johnson, F.R.C.S.I., Hon. Sec. (See advt.)
Royal City of Dublin Hospital.—Honorary Anaesthetist. Applications to Mr. G. Jameson Johnson, F.R.C.S.I., before June 2nd. (See advt.)
Victoria Hospital for Children, Queen's Road, Chelsea, S.W.—Secretary. Salary to commence at £250, to increase to £400.
Woolwich Union.—Resident Assistant Medical Officer at the Infirmary at Plumstead. Unmarried. Salary commencing at £100 per annum, with apartments, rations, and washing. Apply to the Clerk to the Board, Union Offices, Woolwich.

Births.

BENNETT.—On May 23rd, at 33, Vancouver Road, Forest Hill, S.E., the wife of Colin E. Bennett, L.R.C.P. Lond., M.R.C.S. Eng., of a daughter.
MACVICKERS.—On May 25th, at Street, Somerset, the wife of C. G. MacVicker, M.B., of a son.
WEEKES.—On May 25th, at Old Brompton, Chatham, the wife of Holman Weekes, M.D., M.R.C.S., of a son.

Marriages.

BOND LAWRIE.—On May 12th, at Holy Trinity Church, Worcester Charles H. Bond, M.D., D.Sc., of Bexley, to Janet Constance, only daughter of F. R. Laurie, of Worcester.
DEMERIC-HARRIS.—On May 23rd, at St. Mary's Church, Fulham, Henry Eugene de Meric, M.R.C.S., Surgeon to the French Hospital in London, to Edith Huici Harris, eldest daughter of James and Emily Harris, of West Kensington.
MACDONALD-TORDLIFFE.—On May 16th, at the Church of St. Teresa, Ashford, Kent, F. Bedingfield Macdonald, M.B., C.M. Edin., of Preston, Lancashire, to Pauline Mary, eldest daughter of E. Wolferstan Tordliffe, of Tenterden.

Deaths.

CENTER.—On May 16th, at Ardlaw, Carlton Road, Ealing, William Center, M.B., I.M.S., late Deputy-Surgeon-General, Central Provinces.
DAWSON.—On May 18th, at Bedford, Dartmouth Road, Brondesbury, N.W., Richard Dawson, M.B. Lond., of Brunswick Square, Brighton, aged 70 years.
DYER.—On May 21st, Henry Geary Dyer, M.D., of Ringwood, Hampshire, in his 51st year.
EDGELOW.—On May 25th, at 18, Hertford Street, Mayfair, London, Lucy Sarah, the beloved wife of George Edgelow, M.D.
GILFILLAN.—On May 21st, at Walker Street, Edinburgh, Janet Dorothy Gilfillan, M.B., Ch B. Edin. only daughter of Samuel Gilfillan, Hampstead Hill Gardens, London, aged 27 years.
HOOD.—On May 17th, at 13, Calthorpe Road, Banbury, the residence of his father, Alexander Henry Mouton Hood, M.R.C.S., L.R.C.P. Lond., aged 29 years.
MACKINLAY.—On May 28th, at his residence, 15, Stratford Place, London, W., James Grosvenor, L.R.C.S. Edin., L.R.C.P. Lond., M.R.C.S. Eng., eldest son of the late John Mackinlay, M.D., of Isleworth.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXX.

WEDNESDAY, JUNE 6, 1900.

No. 23.

Original Communications.

THE RONTGEN RAYS. IN DISEASES OF THE NOSE, THROAT, AND NEIGH- BOURING ORGANS. (a)

By JOHN MACINTYRE, F.R.S.E., F.R.M.S.,
M.J.E.E.,

Surgeon for Diseases of the Throat, Nose, and Ear, Glasgow Royal
Infirmary; Lecturer on Diseases of the Throat, Anderson's Col-
lege, Glasgow.

Early in the year 1896 I had the honour of giving a demonstration to the members of this Association on the subject of the X-rays as applied to our special department, and to-night I purpose proceeding upon somewhat similar lines, referring more particularly to the advances made in the technique and diagnosis since then. While I have had an opportunity of testing the efficiency of the rays in the diagnosis of affections of the lungs, heart, œsophagus and thorax generally, I will limit myself, although not exclusively, to conditions in these regions which indirectly interfere with the functions of the larynx. Further, I intend to say more about screen than photographic work because much has been done of late in this direction and considering the ease with which information can be got immediately by direct vision it is evident the photographic plate will probably in the future become of great importance only for leisurely study or reference. In carrying out to-night's programme I shall first deal with the technique, including the source of electricity, transformers, interrupters, Crooke's tubes, screens, localisation, and photographic details, and then pass on to the application of the rays in diagnosis, specially dealing with the necessity of careful training and prolonged experience in the interpretation of pictures, permanent or temporary, as they present themselves on the photographic plate or fluorescent screen. From time to time I shall select examples of cases to illustrate my remarks.

With regard to the source of energy, I have nothing to add to what was stated at my last demonstration, because the great increase in facilities for supplying electricity from the mains has convinced us all that where the operator is fortunate enough to be able to dispense with cells, primary or secondary, this source is by far the best. Secondly, where we cannot have electricity from the main, then unquestionably secondary cells hold the first place, but where these cannot be charged, primary cells can still be relied upon, notwithstanding the trouble attached to them. I have seen some excellent work done by men whose enthusiasm had led them to adopt this work, and where the success of their experiments was only equalled by their perseverance under conditions which more fortunate workers in cities cannot possibly understand.

Coming to the question of transformers to excite tubes, we have for the most part in this country used the well-known induction coil, or the Wimshurst machine. On the other side of the Atlantic we owe to Tesla the introduction of a new transformer for the production of oscillatory discharges, a special benefit when using the same great worker's high frequency discharge tubes. Those who have taken a special interest in the subject will have followed with interest the discussions upon the relative value of the Wimshurst machine as opposed to the coil. I will show upon the screen a lantern slide of the large coil giving 28 inches spark, which I use, and one of the largest Wimshurst machines containing 24 plates of 36 inches in diameter, made by the inventor himself. The latter, driven by a motor of one-horse power, has given me most satisfactory results, especially with screen work. Another most valuable feature lies in the fact that the discharges from this machine are not dangerous, the current being so very small. It possesses a third factor of value, which again for fluorescent screen work at least is of importance, namely, the steadiness of the illumination and the complete control of gradual increased or diminution in fluorescence. I need hardly point out that while we have to deal with the early diagnosis of tumour in the chest, it may be of importance to notice movements, and an unsteady screen, or one which does not completely control the vacuum is fatal to the most careful workers. Now, however, in some of the most recent interrupters for the coil, to be described and shown to-night, this last disadvantage has been practically overcome. However, each method of exciting the tube has its advantages. I use both, but many questions, such as portability, accessories, motor power required, and other points usually determine the selection. There is one great advantage in the coil, and that is the power to pass heavy currents through the tubes, especially when we are dealing with the soft tissue. It is true that very much the same result can be got from a tube by increasing the voltage if the current be weaker, but there can be no doubt about the practical advantage of a well constructed interrupter in giving us exactly what is wanted, in voltage and amperage, for a particular tube when required for a special tissue.

Passing to the question of interrupters, since my last demonstration there can be no doubt that it is in this special piece of apparatus that the greatest improvement has taken place. I will show on the screen pictures of a large number of different forms of mechanical interrupters, beginning with the ordinary spring, and then some forms of mercury interrupters, for the most part depending upon the automatic dipping of a piece of metal into the liquid mercury by means of springs or small motors. I will also show one recommended by Dr. Morton of a rotatory form. Lastly, I should like to describe a mechanical form which I devised some time ago and described at a meeting of the Röntgen Society. Those interested in the question of interrupters

(a) Paper read and Demonstration given before the British Laryngological, Rhinological, and Otolological Association, May 11th, 1900.

might refer to the discussion which took place at that meeting; suffice it here to say that the platinum points are brought into contact and retained in contact (within limits) at the will of the operator. This form has been of great service to me inasmuch as it has done away with the inconvenience of the ordinary mercury interrupter, and has allowed me variation in the number of interruptions per second, and what is perhaps of more consequence, the amperage of current passing into the primary of the coil. This apparatus has been made by Mr. Apps, and has given me great satisfaction. Lately, however, a great discovery has been made by the now well-known Wehnelt interrupter, modified by such workers as Campbell, Swinton, and, most of all, by Caldwell. Of late an excellent form, which can be used for hours, has been introduced by Delamore, of Paris, where, by means of a circulation of water in a jacket surrounding the interrupter, the fluid may be kept cool, and the most serious difficulty of the Wehnelt—namely, stopping in its action—can now be avoided. This form of interrupter I am daily using; its only disadvantage was the facility with which Crooke's tubes can be destroyed. Most recent care in its construction has enabled us to modify this disadvantage; but there is no question it is hard upon tubes. Lately, Messrs. Isenthal, Potaler, and Co. have introduced a mercury jet interrupter, having a jar with paraffin of high flash point. At the bottom of this jar a quantity of mercury is placed, which is pumped up by centrifugal force, and as the vanes pass this jet the make and break of the current are obtained; and as the metal strips are flat-pointed and broad at the base, by very slow adjustment the jet can be raised or lowered so that we can regulate the amount of current passing to the primary coil. By these means we so obtain a thicker spark in the secondary while the number of interruptions can be varied from a few hundreds to fifty thousand per minute. I am now frequently using the jet form of interrupter and have nothing but good to report upon it, all the same, the Wehnelt as I have said, is one of the greatest advances of modern times.

The next piece of apparatus of importance is the Crooke's tube itself, and indeed in all X-ray work it may be said that a good tube is the secret of success. For general excellence and where heavy currents are not employed, the form first selected by Herbert Jackson and made by Newton still maintains its excellent reputation. Lately, some magnificent tubes have been placed in my hands by Messrs. Isenthal, Potaler and Co., and especially those with a very thick anti-cathode bore to use with the Wehnelt's interrupter. To my mind, however, for a particular work a most important thing is to have the proper vacuum for a given piece of work. Tubes vary very much, temporarily and permanently, and all sorts of devices are now employed, as in the very excellent tube shown to-night of Mr. Cossar for lowering the vacuum when it is too high. Another matter of great moment is to have some automatic regulation for keeping the vacuum the same during the excitation of the tube. Probably the most ingenious is the Queen's tube (an American form) whose only fault lies in its expense. Personally, I find it of the greatest advantage to be able to arrange the vacuum of a particular tube to suit one's purpose, and to be able to maintain its vacuum the same during an experiment. On the screen I have, therefore, shown my special arrangement of a Sprengel pump to which is attached a small plunger or steel pump to keep up a circulation of mercury. By means of this valuable addition and automatic cutout for the small motor which drives the pump (for both of which I am indebted to Lord Blythwood, who kindly presented

them to me) I am able without the least muscular exertion to bring the tube to any desired vacuum.

It will be found by all those who have attempted to make Crooke's tubes for themselves that there is a critical condition of exhaustion for special subjects, and no doubt this can be well determined by the proper use of the Sprengel or other exhausting pump. Naturally, however, as the current passes through the tube, the resistance rises until after a period heating begins, then the vacuum falls. Many devices have been suggested to correct this, for example, a little caustic potash in a separate compartment may be employed. By heating this we can so far correct the vacuum. Again the tubes have been surrounded with wires to be heated throughout the exposure, ordinary electric wires to be applied to the bulb, which can be attached to the main, and again a certain degree of vacuum is maintained. A permanent rise in the vacuum results from continued use, and temporary fall always follows heating. Siemens and Halske take advantage of the fact that vapour of phosphorus under the influence of an electric current tends to attach itself to the walls of the tube, and they supply an auxiliary tube containing the vapour, and provided with an arrangement for connecting with the ordinary current. The terminals and the cathode are connected when the vacuum gets too low, and the auxiliary tube can be heated by means of a lamp if the vacuum is too high. Queens, of Philadelphia, have made an excellent tube based upon the two physical properties of vacuum tubes, to increase the resistance with the increasing height of the vacuum and the heating power of the cathode rays. In this case the small bulb containing the chemical gives off a vapour when heated, and reabsorbs it when cool. This is indirectly connected with the main tube, and is surrounded by an auxiliary tube which is exhausted to a low vacuum. When it is in operation, the vacuum of the main tube being high, and consequently having high resistance, the current takes the path of least resistance, heats the chemicals in the small bulb, and the result is a lower vacuum in the main tube, and as soon as it reaches a certain point, the current again seeks the path of least resistance; in other words, it goes through the large bulb excited by the molecules within and thus produces X-rays. The moment the vacuum rises in the large tube it is immediately corrected by the current again finding the path of least resistance, and so we have not only the means of regulating the vacuum, but it is done automatically. The objection, to my mind, apart from the question of expense, is, that so far any specimens given to me, have heated too rapidly under the influence of any of the ordinary interrupters, but doubtless the makers of this tube will, as far as possible, overcome this difficulty.

Of fluorescent screens I should like to say a word. I have experimented with most known forms of fluorescent substances, and for practical purposes my experience confirms what Jackson has said that the barium-platino-cunide is the best. When I last gave my lecture a great deal was said about the calcium tungstate salt suggested by Mr. Edison. In this direction I have a curious story to tell. American workers were constantly using this salt, and to quote Mr. Edison, "it was much more brilliant than any other salt." I tried the very best makers, and had the salts specially prepared for me by expert chemists both in Germany and at home, but I could not find this statement to be correct. At last I sent to America, and through the kindness of Dr. Morton, obtained the best salt to be made there, and a fluorescent screen tested there and approved of, but with precisely the same result. After long and wearied experiments, however, I had the satisfaction of hearing from Dr. Morton, that the explanation

possibly lay in the fact that when first the X-rays were discovered, the workers on the other side of the Atlantic had poor specimens of barium salt, compared with the calcium tungstate, and I am led to believe also that the workers now in America are using good specimens of barium-platino-cyanide salt. The potassium-platino-cyanide salt is more fluorescent but not so durable. A paper written in the present state of our knowledge would be incomplete without some reference to localisation of foreign bodies. Fortunately, this can now easily be done, so that the exact position and depth from the surface of the foreign body can be determined previous to operation. As early as March, 1896, my attention was called to the subject, and at a demonstration which I gave to the Philosophical Society showed how this could be accomplished. My friend, Mr. James Buchanan, of Peter's College, Cambridge, worked out the problem from the mathematical standpoint. The principle was the casting of two shadows from different standpoints upon the same or two different photographic plates, the crossing of the rays indicating the situation of the object. Many valuable suggestions have been made during the past four years in this direction by Moore and others, and practical instruments have been devised by Payne, Thompson, Hoffman, Moulin, McKenzie Davidson, Dr. Fleming and others, and a modification of a French (Marcy) one. Further, the subject is so far developed that we can often dispense with photography and use the screen alone. I am at present working with a new instrument upon these lines adapted for our special department, which I hope to show in the future to our members. I need hardly say more than point out that in many instances I have found the procedure of great value, and, in fact, no well-equipped hospital can afford to be without some means of localisation. And here I would say that many workers have pointed out the advantages which operators might obtain by abstracting the foreign body while they are looking at the fluorescent screen. I should think that this could be suitably done with greater prospects of repaying the trouble involved when we use stereoscopic vision, but notwithstanding the fact that I have had tables constructed with leather tops, so that the tube might be put below the patient and the screen over him, I have not found the method of supreme advantage. Doubtless, one can see the instrument being introduced to the site of the foreign body, but probably, because of a special training, one gets used to the use of ordinary methods. I have always found the accurate localisation of the foreign body sufficient, but I need hardly say that there may be cases where it would be a distinct advantage to see the instrument grasping the foreign body *in situ*.

Upon photographic details very much could be written; suffice it here to say, however, that great advances have been made in suitable plates for X-ray work, and Eastman's people have conferred a benefit upon surgeons, where it is of importance to see at once the results of photography, in the X-ray paper they now prepare. By this means the surgeons can, a few minutes after exposure, have a positive instead of waiting for the completion of the sun picture. It need hardly be pointed out that the quicker the exposure the better for the patient, especially in our department, where difficulty in breathing is often a source of trouble. In most cases of this nature it is wise to have a temporary arrangement for cutting off the current with the heave of the ribs, especially when the extraordinary muscles of expiration are brought into play. Personally, I have been paying more attention to obtaining different densities in tissues, which of course in lower vacuum tubes means longer time.

Two years ago, at the Royal Society, I saw a number of plates of the chest taken in ten seconds without the aid of a screen. Messrs. Isenthal, Potsler and Co., however, inform me that very rapid plates will shortly be in the market, and by their aid instantaneous photographs of the chest may be expected by using also the fluorescent screen. I do not, however, like the fluorescent screen, as the picture is never so well defined.

(To be concluded in our next.)

Paris Clinical Lectures.

ON SCAPULO-HUMERAL PERIARTHRITIS.

DELIVERED AT THE HOTEL-DIEU.

By DR. SIMON DUPLAY.

Professor of Clinical Surgery at the Medical Faculty of Paris;
Surgeon to the Paris Hospitals.

You have just seen in our wards a fairly typical case of an affection, which I described in 1872 under the name of scapulo-humeral periarthrititis. The patient in question is a man, *æt.* 59, who was admitted into hospital on March 9th. There is no morbid family history, and he himself has always been in excellent health, without the least trace of any diathesis, never having even had an attack of rheumatism. The only fact worthy of note is that, in working at his trade (bellows-maker), he makes constant and energetic use of the right scapulo-humeral joint.

On February 19th, that is to say, twenty days before his admission into our wards, he fell and struck his right shoulder against a plank at a point four fingers' breadths below the acromion. This spot is now extremely tender to pressure.

After a rest of four or five days, during which he suffered severely, he tried to resume work, but was obliged to give it up within an hour. A medical man who was consulted ordered liniments and poultices. A few days later, another attempt at resuming work failed, not only on account of recurrence of the pain, but also because of a certain stiffness of the shoulder-joint, which the patient then noticed for the first time. As no improvement took place he made up his mind to come to the hospital.

On examination we find that the right shoulder is slightly lower than the other, and there is a slight flattening of the deltoid region, without any other perceptible deformity. The patient does not now complain of spontaneous pain, as during the first few days immediately after the accident, but there is great tenderness to pressure and pain in moving the arm. The movements are limited, both on account of this pain, and because the stiffness, observed by the patient about a fortnight after the accident, still persists.

The features consequently which present themselves for consideration in this case are:—(1) Pain; (2) functional disturbances.

The pain, which is almost nil spontaneously, is determined only by movements of the shoulder-joint and by pressure at certain spots, *viz.*, the bruised point four finger's breadths below the acromion, and over the point of attachment of the deltoid to the humerus. There is no certainty as to the existence of any other tender spots, the patient's statements being rather confused on the subject of tenderness at other points, where pain is usually felt in the affection under consideration. The painful phenomena, moreover, are closely connected

with the functional disturbances, and manifest themselves, as we shall see, only at a certain stage of a movement.

In order to thoroughly examine the spontaneous or active movements of the scapulo-humeral articulation, the examiner should place himself behind the patient, so as to be able to compare the diseased with the healthy side of the body. When the patient is ordered to execute on the healthy side the movement of abduction or raising of the arm outward, the scapula remains absolutely immovable until the arm occupies a horizontal position, forming a right angle with the vertical axis of the scapula. If the upward movement is continued, the scapula begins to change position, the projection formed by the lower angle moving outwardly toward the axilla, in proportion as the arm is raised from the horizontal position.

On the diseased side, on the contrary, as soon as the arm is separated far enough from the body to form an angle of barely 45 degs. with the vertical axis of the scapula, the latter is involved in the movement, which, moreover, cannot be continued as far as on the other side, the patient being only with difficulty, and by bending the head and upper part of the body, able to touch his head with the hand.

All other movements in the affected joint are impaired to the same extent, backward flexion somewhat more than forward flexion, while rotation and circumduction are also very limited. The scapula invariably takes part in all these movements, though in none so distinctly as in the movement of abduction.

These features, which are perceptible on simple inspection and by the aid of volitional movements, become still more distinct when examined under induced or passive movements, abduction in this case also furnishing the most conclusive evidence of the nature and degree of the obstacle.

When, on the healthy side, the elbow is bent with one hand, while the scapula is held firmly with the other at its lower angle, the arm may be raised until it occupies a perfectly horizontal position without the scapula being moved. It is only when the movement is carried beyond a right angle that the scapula is felt to undergo displacement so as to participate in the movement of the humerus.

If the same manoeuvre be repeated on the diseased side, the arm may be slowly raised from the body up to about 45 degs. without the scapula budging, but beyond this the movement is communicated to the latter, and if an attempt is made to prevent it from changing place, the patient immediately experiences severe pain in the shoulder. The same remark holds good of other movements.

It is a point of capital importance in respect of the diagnosis that within certain invariable limits the articulation appears to be normal without impairment of the mobility or manifestation of the pain, but, as soon as this limit has been passed, there is a physical obstacle, which determines pain when an attempt is made to overcome it.

This stiffness of the shoulder, which manifests itself in the passive movements, shows that the condition is not the result of muscular lesions, such as atrophy of the deltoid, which indeed is very slight in this patient. The first theory that suggests itself is that we have to do with a joint-affection, though this could only be in the course of development, seeing that there is no deformity, swelling, or spontaneous pain. It could consequently be neither an acute nor a chronic arthritis, but an incomplete ankylosis, following an arthritis of traumatic origin at present recovered from, though having resulted in the formation of bands and adhesions, restricting the normal movements of the joint.

This was, indeed, the diagnosis constantly arrived at before the existence of scapulo-humeral peri-

arthritis was known. I have a vivid recollection of the case of a woman, presenting this special stiffness of the shoulder in a very marked degree, in whom I determined to break the adhesions, which I did under chloroform with a very distinct perception of rupture taking place. On the following day I expected to find a more or less acute attack of arthritis, but to my great astonishment there was absolutely no pain in the joint. The rupture which I had felt, therefore, had not taken place in the joint, a fact which showed that the situation of the lesion was extra-articular.

If we remember the large bursa mucosa situated beneath the acromio-coracoid ligament and the deltoid, enveloping the upper extremity of the humerus, and constituting a second articulation, as it were, externally to the true joint, so as to facilitate the movement of the head of the humerus against the acromio-coracoid apparatus, it is easy to see, that this is the place where the lesion existing in the patient under discussion has developed. As a matter of fact, lesions of this supplementary joint determine functional disturbances, closely simulating those resulting from intra-articular lesions. They are as a rule of traumatic origin, and follow contusions, dislocations, or fractures in the neighbourhood, though sometimes they are spontaneous, of inflammatory nature, and develop in the infra-deltoid bursa mucosa under the influence of various causes.

Clinical observation thus gave me the first clue to the true situation of this affection; but my conclusions were confirmed at the autopsy on a case, described in the monograph which I published in 1872. I found that there were no morbid changes whatever in the joint, whereas the infra-acromio-coracoid and infra-deltoid bursa mucosa had entirely disappeared, being supplanted by extremely dense fibrous bands, which united the head of the humerus to the acromio-coracoid apparatus and the under side of the deltoid. These fibrous bands may take in the various branches or even the nerve trunks of the brachial plexus, thus determining neuritis, followed by pain and sometimes even by very severe trophical disturbances, which are almost entirely lacking in the present case.

Since then several autopsies have been made on cases of this kind, and I have myself had the opportunity of making another, the results of which were identical with those of the first. The situation and nature of scapulo-humeral peri-arthritis are therefore at present well understood.

The distinctive features, from a clinical point of view, of this affection are: the absence of any obvious joint-lesion, or of any symptoms pointing to the previous existence of one, and the character of the pain and functional disturbances.

Spontaneous pain in the joint, sometimes radiating as far as the elbow, is of frequent occurrence in cases of arthritis, but is rare in peri-arthritis, and, if it does exist, it takes the form of neuritic pain for the reason mentioned in connection with the pathological anatomy of the lesion.

Tenderness to pressure in arthritis exists at the accessible spots of the joints, that is to say, in the axilla and in front in the interstice between the deltoid and pectoralis major. There is no tenderness whatever at these spots in peri-arthritis, in which, on the other hand, pain may be determined by pressure immediately below the acromion and coracoid process, as well as over the area of attachment of the deltoid to the humerus.

There is also an essential difference between arthritis and peri-arthritis in respect of the pain determined by motion. In arthritis, movements of all kinds are painful, whereas, in peri-arthritis, certain or rather all movements may be performed without the least pain up to a certain invariable limit, the pain

only beginning to manifest itself when this limit has been reached.

Lastly, the functional disturbances also differ widely in arthritis and in peri-arthritis. The stiffness associated with arthritis is such that every movement of the humerus involves more or less the scapula, and if the arm, held at a slight distance from the body, is adducted, the scapula moves toward the midline, an outward movement of the arm being also associated with displacement of the scapula in the same direction. In peri-arthritis, on the contrary, all movements are absolutely normal, without participation of the scapula, as long as the aforementioned limit, which for the abduction is usually represented by an angle of 45 degs., is not exceeded. This phenomenon is accounted for by the laxity of the adhesions, which, when there is no joint-lesion, permits of a certain amount of motion in the articular surfaces, the scapula not being pulled along until the limit of extension of the adhesions has been reached. This explains also why it is invariably in abduction of the arm from the body that the scapula participates in the movement, adduction of the arm not resulting in stretching the fibrous bands and the scapula therefore remaining stationary.

A differential diagnosis between stiffness due to arthritis and that dependent upon the existence of scapulo-humeral peri-arthritis may, therefore, always be arrived at by careful examination of the pain, and especially of the functional disturbances.

The prognosis of the affection is grave if it remains unrecognised, so that a suitable treatment cannot be instituted. The adhesions, indeed, have no tendency towards disappearing spontaneously, but gradually become firmer and more unyielding, ultimately determining as serious a form of ankylosis, as if it were the result of intra-articular lesions.

If, on the other hand, a correct diagnosis had been early arrived at, and the affection is suitably treated, the prognosis is comparatively benign.

Mistaking a peri-arthritis for an arthritis, moreover, is a serious matter in more than one respect, for not only is nothing done for curing the peri-arthritis, but by resorting to the usual treatment of arthritis, that is to say fixation of the joint, the formation of adhesions and fibrous bands is favoured, the subsequent treatment of the real trouble being thereby rendered more difficult and less efficacious.

With regard to the treatment of scapulo-humeral peri-arthritis, immobilisation and the use of local resolvents should only be resorted to in the beginning and during the period of acute pain. As soon as this stage is over, recourse should be had at once to massage, kinesiotherapy, douches, and electrification.

During the chronic stage, when there is stiffness constituting a pseudo-ankylosis, if this is slight, recovery is frequently obtained by persistent, energetic use of the measures alluded to. Should, however, no improvement take place under this treatment, or if the stiffness is very marked and of old standing, it is necessary to break the adhesions under an anæsthetic. The muscular contraction being thus done away with, the scapula is fixed by means of a large folded towel applied to the affected side in such a manner that the ends can be drawn tight on the other side, or simply by the hands of a strong assistant applied over the upper edge of the bone, after which the arm is first placed in the position of forced abduction, and then moved successively in every direction. The rupture of the adhesions is manifested by snapping which frequently is perceptible to the ear, the sound sometimes being so loud as to make the operator somewhat anxious about the result, though no ill-effects have ever been observed from this treatment.

After two or three days' rest, it is of great impor-

tance, in order to avert reproduction of the adhesions, to resort to the vigorous treatment recommended for use at the onset of the affection. In some exceptional cases, in spite of subsequent treatment, it will be found necessary to have recourse a second time to sudden breaking of the adhesions under chloroform, in order to ensure complete recovery.

NEW ENEMA NOZZLE.

By ALEXANDER DUKE, F.R.C.P.I.,

Cheltenham.

THE principal value of an injection when administered, and the entire good of a nutritive enema, is lost if the fluid injected is not retained for sufficient time.



The ordinary form of enema nozzle fails to retain the fluid when injected, and so pressure round the tube with fingers, sponge, napkin, &c. (as recommended in the various text-books), is quite insufficient. By pressing the nozzle (depicted in illustration) firmly into the bowel the injection is effectively retained so long as nozzle is held, its wedge shape plugging the anus and forcing the sphincter to embrace it closely.

When administering an enema to children their struggles and efforts to expel the tube makes it a difficult matter, but by using the form of nozzle described the difficulty is got over completely.

The nozzle will also be found most useful in cases where it is necessary to administer copious saline enemata, now so valuable in excessive hæmorrhage, suppression of urine, and shock. The nozzle also possesses another advantage, it has no tendency to retain any faeces while being removed from the bowel, its shape also rendering it easier of being kept clean.

The makers are Messrs. Sumner and Co., Lord Street, Liverpool, who keep the nozzle in two sizes for adults and children.

DORMIOL IN INSOMNIA.

By J. MOIR, L.R.C.P.Ed.

OWING to our present high pressure mode of life, and the stress of competition, insomnia, unfortunately, becomes more and more prevalent from year to year, and although it is found to some extent among the poor and ignorant, it overtakes the educated and intellectual in still greater proportions. The man of high mental culture, occupied with the contemplations of his own mind is far more likely to suffer from insomnia than uncultured and illiterate persons, in consequence, probably, of the abnormal pathological conditions induced by sedentary habits, and the altered conditions of the circulation within the cranium. Insomnia, too, is well-known to afflict some of our great statesmen, and others on whom weighs the responsibility of important business transactions.

A great number of cases of insomnia are also due to epidemic influenza, from which we have suffered for the past ten years, and which as yet shows no signs of disappearing from our midst, notwithstanding its previous unaccountable disappearance for nearly fifty years. Then, again, in all the acute and infectious diseases, delirium and insomnia are pretty constant factors, in rheumatic fever, in pneumonia, dysentery, meningitis, and in typhus, enteric fever, small-pox, and the other zymotics. To these must be added the insomnia of insanity itself, the worst infliction probably of them all.

The causes being so numerous, and the effects so disastrous, it is necessary, then, above all things that for insomnia we should have a thoroughly reliable, and at the same time, under proper precautions, harmless, hypnotic sleep-procurer, which is also, as far as possible, pleasant to take and speedy in its action, without deleterious or cumulative after-effects. This, of course, would, and must only be supplementary to such ordinary precautions as rest in bed, baths, change of air, cheerful society, music, and the like, which everyone recognises as the primary indications, along with change of occupation, frequently required in cases dependent on mental alienation or disturbance, and in the case of acute and infectious diseases, in addition to the ordinary remedies suitable in each individual case.

Such an hypnotic, we believe, from personal experience, is to be found in Dormiol (Amylenchloral).

Chloral hydrate, the great hypnotic introduced by Liebreich, with its many advantages possesses some disadvantages. In addition to the headache it is frequently apt to induce after its administration, there is, above all, the danger of collapse, owing to its action upon the heart, as pointed out long ago by Dr. John Hughes Bennet, a former well-known professor of physiology in the University of Edinburgh. Then we have, amongst others whose name is legion, paraldehyde and amylen hydrate, which are in experience found to be often very useful. But in 1898 Dr. Fuchs, of Stolberg, discovered amylenchloral, to which he has given the name Dormiol, of which the first account is given in "Experiments Regarding the Sedative and Hypnotic Action of some *Materia Medica*" (*Münch. Med. Woch.*, No. 37, 1898). From these experiments it would appear that the toxic effects of dormiol are much slower in their action than those of chloral hydrate, and consequently can be much easier guarded against, and also that with due care they can be prevented altogether, which is not always the case with chloral hydrate. Dr. Meltzer, of Colditz, in the Royal Asylum at Untergoeltzsch, states:—"I undertook the task of testing the action of dormiol, because no other hospital physician will ever have such a number of patients for whom an hypnotic is a necessity; secondly, because in psychiatric practice, especially if the building itself is unsuitable, necessitating the crowding of chronically restless cases, it is of value to have a number of sedatives and hypnotics at our disposal, which enable us to vary them, thus preventing the patients from getting used to one." (*The Therapist*, March 15th, 1900.) Dr. Meltzer was successful with dormiol in 75 per cent. of male and 80 per cent. of female patients, most of them very restless, including excited paralytic patients, where even hyoscin acted less promptly, and believes that if he had given dormiol exclusively in sane, not excited patients, the percentage would undoubtedly have been much higher. It did not act so well as a sedative as an hypnotic, nor by day as by night. Doses of $7\frac{1}{2}$ grains sufficed for producing a quiet, dreamless sleep in nervous people, invalids, and old people, even psychically excited persons; 15 to 30 grains answered equally well, producing sleep; nothing else, 30 to 45 grains were *always* effective. Ninety grains, the same as chloral hydrate may be considered a daily dose. Dr. Meltzer also says he was informed that dormiol had been given with good effect, and without any after ill effects in heart disease, and recommends less doses in these cases given in capsules. He succeeded with dormiol where chloral hydrate failed, and concludes that it is a good hypnotic in doses of $7\frac{1}{2}$ to 45 grains, without unpleasant bye or after effects, even in insane patients, who are in a more or less excited mental condition.

By these facts I was induced to give dormiol a trial in three forms, full strength, 10 per cent. dilution,

dose 70 to 140 minims, and capsules containing $7\frac{1}{2}$ minims.

CASE I.—W. J. C., engine driver, æt. 43, suffering from rheumatic fever, had no sleep for a week. I gave him two capsules, each containing $7\frac{1}{2}$ minims, in the course of the eighth day, with the result that the sleeplessness was relieved, and that symptom was removed. He had, of course, in addition, the treatment necessary for his complaint.

CASE II.—Mrs. K., æt. 50, suffering from nervous depression, despondency, and sleeplessness. At night, for several nights, 30 minim doses were given, with the result of procuring sleep, and on the nights dormiol was omitted she did not sleep.

CASE III.—R. P., æt. 52, labourer, suffering from enteric fever of low, adynamic type, with symptoms of rheumatism, restless and sleepless. On one occasion he was given six capsules, containing $7\frac{1}{2}$ minims each, two, three times a day, with good hypnotic effect, but he died in the Royal Bucks Hospital, from exhaustion due to his illness.

CASE IV.—R. S., schoolboy, æt. 13 $\frac{1}{2}$, suffering from influenza and delirium, on two nights had 30 minims of the 10 per cent. dilution dormiol, producing better rest and sleep, and omitting it the third night found that he had slept fairly well, so that I did not again resort to it. He recovered in twelve days after the attack commenced, and was then put upon Parrish's food to get up his strength and appetite.

CASE V.—P. T., æt. 35, artist, suffering from the effects of alcohol, extremely nervous, with total loss of sleep for several days. I gave him bromide of sodium and calumba mixture three times a day, and each night for a week 40 minims doses dormiol at bed time, with the result that at the end of the week he could eat and sleep, without medicines, and was able to resume his occupation. On each night that he took the dormiol he had a good sleep, but from the feeling of nausea from the drink he was not able to use the brush or the pencil until the week had elapsed.

From these cases I have come to the conclusion that dormiol may be relied upon as an hypnotic, where other remedies might be likely to fail, or considered otherwise unsuitable. In each case, except where the capsules were used, I gave the medicine plentifully diluted with water, usually as a two ounce draught. This is advisable, as then it has only a pleasant camphor-like taste. I never observed any bad symptom at any time, the dormiol acting as a pure hypnotic, and producing no other effect whatever either on pulse or temperature.

Therapeutic Notes.

By GEORGE FOY, M.D., F.R.C.S.

TYPHOID.—SOME LESIONS.

Of the sequelæ of typhoid fever one of the last to receive attention was bone lesions. The earlier papers of Vidal and Maisonneuve in 1835, and of Chassagnac in 1854, attracted little attention in this country; and it was not until the appearance of Paget's article (1877) in St. Bartholomew's Hospital Reports that British physicians directed their attention to it. Soon afterwards a number of valuable papers appeared on this, one of the most painful and distressing of the sequelæ of typhoid fever. When the typhoid bacillus was discovered, and for some time afterwards, it was thought that osseous tissue was impervious to its attacks. But when bacteriological examination of bone came to be made, the typical bacillus of the disease was found in the marrow of the bone and in the bone tissue itself. The earlier symptoms of bone trouble following typhoid are now easily recognised as due to this cause, and in the detection of the first stages of periostitis the Rönt-

gen rays have proved of much use in the hands of Dr. Moffatt, whose paper on "Typhoid Bone Lesions" (*Occid. Med. Times*), giving the clinical history of some cases that came under his care, are graphic pictures of the lesions. His deductions from his own cases and the cases reported of others are as follows:—

1. Nearly always we have to deal with osteo-periostitis or an osteo-myelitis.
2. The tibia, ribs, and femora are the bones most frequently attacked.
3. The onset of the inflammation does not occur until convalescence has commenced, or not till months or even years after the disease.
4. They occur much more frequently in men.
5. More cases occur before 30 years of age than after it.
6. Old fractures and severe muscular strain predispose to the lesion and its location.
7. Streptococci and typhoid bacilli flourish for long periods together.
8. General symptoms are lacking, temperature is as usual.

ANÆSTHESIA EXPERIMENTS ON MOTOR NERVES.

Senor Marney has presented to the Academy of Science of Paris some notes of Drs. Joteyke and Stefanowska (*El Siglo Medico*), on the inhibitory effects of anæsthetics on living motor nerve tissue; showing that under the influence of chloroform, ether, morphia, chloral, and alcohol, the function of the nerve is suspended, and that it becomes incapable of reacting to the most powerful stimuli.

(1) General anæsthesia of the nerve. One wire of a galvanoscope is introduced into a small glass bell, which holds a sponge soaked with chloroform or ether. The excitability of the nerve to be examined is tested. Tetanised for a very short time. It soon appeared that the reaction to the stimulus gradually diminished in intensity, and finally ceased altogether, the time varying in proportion to the density of the anæsthetic vapours; the nerve slept, and its functions were in abeyance.

To show that the nerve was still living, the connection with the galvanoscope was broken, and little by little the excitability was regained and the contractions were renewed in their former intensity.

The excitability of the nerve was methodically tested at the beginning of the experiment in different regions. In all its length it was found that the excitability was first lost near its centre, and last, at its periphery; but the restoration of the excitability was in inverse order. Muscle is much more refractory to the anæsthetic than nerve, but the difference is one of degree only.

LOCAL ANÆSTHESIA.

The local action of the anæsthetics was tried by wrapping a portion of the nerve trunk in a thin layer of cotton wool wetted with chloroform or ether.

Having applied the anæsthetic on a part close to muscle tissue, and placed the electrodes in connection with the upper part of the nerve, the following effects were noticed.

1. At first, in some cases, the anæsthetic slightly increased the functional excitability of the motor nerve.
2. In all cases at the end of a little time the nerve lost its power of conductivity, but the stimuli excited the central portion.
3. If the anæsthetic is now removed from the nerve its frictional activity soon returns. Ether does not kill the nerve, but chloroform has done so. The experimenters appear to have used the same amount of ether and chloroform, but as the dose of chloroform is one-tenth that of ether the lethal dose of chloroform was applied, but only the therapeutic one of ether.
4. The diminution of the conductivity of the anæsthetised nerve was shown, not alone in the diminished contractility of the muscular tissue, but also in the diminished velocity of the nerve current.
5. The anæsthesia is confined to the part of the nerve treated, and cannot be said to be propagated either centripetally or centrifugally.

6. Sensory nerves are similarly affected.

Finally, anæsthetics are capable of producing abolition of function, both of sensory and motor nerves. This loss of function in purely motor nerves was produced in a frog by the action of anæsthetic vapours applied to the nerve throughout its length and on isolated portions of nerve.

In cases of general anæsthesia the different parts of the nerve were found to act independently, from which the scientists deduce that the sensibility of the nerve in relation to anæsthetics is not the same in all its parts.

In cases of local anæsthesia it was found that the part of the nerve anæsthetised wholly lost its functional powers—conductivity and receptivity.

APHONIA NERVOSA.

For the treatment of this troublesome affection Dr. Oliver (*La France Medicale*) recommends that the patient be instructed to draw in a deep tranquil breath, and then to try to produce a clear sound on expiration. From this they proceed to articulate vowels, syllables, and finally words of two or more syllables. In some cases the patient spoke clearly and distinctly after five minutes' practice. The author thinks that some of the good effects of the treatment are due to suggestion.

EPILEPSY.

Dr. Lydson (*Therapeutic Gaz.*) remarks that his experience is:—

1. Epileptic patients show better results under santonin than under the bromides.
2. Santonin acts well in cases in which bromides, for one reason or other, are not tolerated at all.
3. Santonin gives distinctly beneficial results where the bromides fail altogether.
4. Santonin is free from injurious effects, which cannot be said of the bromides.

Especially is it free from such effects as melancholia, mental hebetude, profound nervous and circulatory depression, and disfiguring eruptions. Such disagreeable physiological effects as santonin produces are not severe as a rule, and are transitory.

CHRONIC URETHRITIS.

Dr. Horwick, in the same journal, gives it as his opinion, that in dealing with follicular urethritis the most beneficial results are obtained from the employment of a steel bougie which has been anointed with Fluger's ointment, which is composed of:—

R Iodine, grs. v;
Potass iodid, grs. xxx;
Ol. olive, ʒss;
Lanolin, q.s., ut fiat, ʒj.

Mix.

The instrument covered with the salve is passed into the urethra and left *in situ* for the space of five minutes; the surgeon, at the same time, making gentle massage along the under surface of the urethra. The diseased glands will be distinctly felt to roll under the finger as it is passed along the route of the canal.

LENIGALLOL.

Lenigallol, triacetate of pirogallol, is a white powder, insoluble in water, but soluble in alkaline solutions. Its action is confined to the diseased tissue, the sound skin being unaffected. In psoriasis and eczema it gives good results. The following formula is the one generally adopted:—

R Lenigallol, 5 parts;
Zinc ointment, 100 parts.

EUGALLOL.

Eugallol, monoacetate of pirogallol, is a syrupy fluid of a mud-brown colour, soluble in alcohol, ether, and water. It acts as an irritant to the healthy skin, but if applied carefully on a pencil to the diseased tissue it produces the best results. It is also employed mixed with equal parts of acetone.

ALCOHOLISM AND MORPHINISM.

Dr. Wenthers has used successfully the following for both whisky and morphia craving:—

R Ammon. bromide, gr. v;
Ext. bellad. fld., min. ij;

Ext. nucis vom. fld., min. ij;
Ext. cannabis ind. fld., min. ji;
Aqua ad., 3ij.
Ft. haustus—One four times a day.

DYSMENORRHEA.

R Tincture of piscidia;
Tincture of viburnum;
Tincture of hydrastis;
Tincture of opium.

Of each equal parts. Mix. Twenty drops three times a day.—*Corriere Med.*

GENERAL MEDICAL COUNCIL.

SIXTY-NINTH SESSION.

Sir WILLIAM TURNER, President, in the Chair.

SIXTH DAY.—MONDAY, MAY 28TH, 1900.

PREVENTION OF PERSONATION.

THE Council in Committee resumed the consideration of the report of the Committee on the Prevention of Personation, adjourned from last session. The report sets forth that the subject of fraudulent personation and the cognate subject of the accuracy of the *Medical Register* have engaged the attention of the Council and the Branch Councils on several occasions, but the Committee stated that by the efflux of time the precautionary means adopted at the commencement of the *Medical Register* appeared to be now insufficient. Concerning the insertion of an original entry on the *Medical* or *Dental Registers*, the Committee proposed that a general principle underlying the identification of applicants and a specific method of helping to secure that identification should be adopted. As the underlying principle they proposed that the Council should endeavour to obtain, as was done in the case of the chief Universities of the United Kingdom, a consecutive official record of the chief stages of the practitioner's career, beginning with the commencement of his studentship, and they recommended certain alterations in the present procedure, by which the identity of the person seeking registration would be secured. They also recommended alterations in the standing orders governing the restoration of the name of a practitioner to the *Registers*. Of all possible channels of fraudulent personation of practitioners whose names were still borne upon the *Medical* or *Dental Register*, the Committee believed that the issue of certificates of registration was the easiest, and suggested that henceforth no certificates of registration of the current form should be issued by the Registrar of the Council. They submitted a series of formal recommendations on the subject.

Mr. HORSLEY moved the adoption of the Committee's first recommendation, viz., that where application is made for registration in the *Students', Medical* or *Dental Register*, under exceptional circumstances, the facts of the case should be furnished in the form of a Statutory Declaration.

Some discussion ensued on the scope of the recommendation, and ultimately, on the President's suggestion, the reference to the *Students' Register* was struck out, Dr. ATTRILL observing that there was much more danger of personation at the examination than upon these certificates.

The amended recommendation having been agreed to, the Council passed to the next, which provides that in all cases the forms of application shall be filled up in the applicant's handwriting, and in applications for restoration to the *Registers* the applicant shall furnish a Statutory Declaration of his case as well as a certificate of identity.

Some discussion took place on the value of handwriting as a means of identification, the REGISTRAR holding that, though useful as corroborative evidence of identity, it would in many instances not be available, owing to the number of cross-registrations.

Mr. G. BROWN said the revision of the rules governing registration would relieve the Registrars of much responsibility, and he characterised the Registrar's objec-

tions as hypothetical. He observed that it was inadvisable that a man should be able to rush in and demand registration at a moment's notice, and he suggested that the documents might be required to be left with the Registrar for a week for examination before proceeding to registration. He added that students who had registered in Ireland or Scotland ought to be registered, when qualified, in the same division of the kingdom, a suggestion which the President objected could not be legally enforced.

In answer to a question the REGISTRAR said that qualifications were not registered on the strength of the lists supplied by the various licensing bodies, personal application being also required.

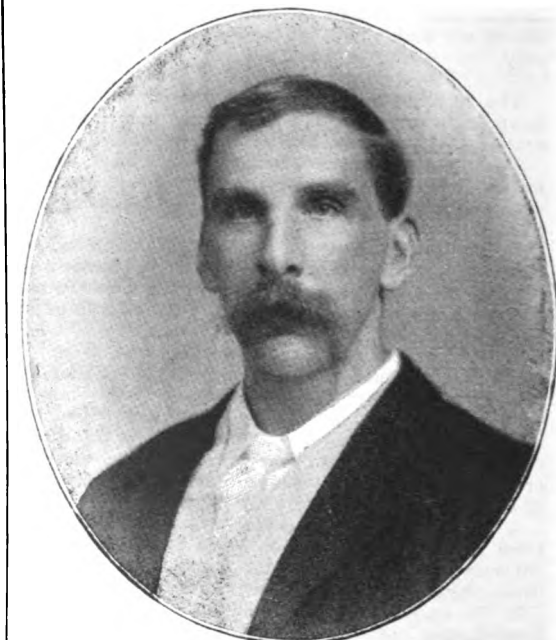
Dr. McVAIL raised the question whether the Council had the power to interpose any hindrance to registration, a point on which the President thought the Council ought to be advised.

Ultimately the report was referred back to the Committee with power to take legal opinion in regard to the legal questions raised thereby.

THE QUESTION OF RECIPROCITY.

The question of reciprocity of medical practice in regard to Italy, which was referred to by the President in his inaugural address, was next considered. Communications on the subject were read from the Privy Council, together with a copy of a despatch from Her Majesty's Ambassador at Rome to Lord Salisbury. Lord Currie enclosed a copy of a letter addressed to him by a deputation of British practitioners resident in Italy, stating that in their opinion the privileges enjoyed by them in Italy were just and reasonable and would therefore justify the application to Italy of Part 2 of the British Medical Act of 1886, so soon as those privileges had been confirmed by the Italian law now under consideration on the basis of reciprocity. In connection with this communication the British Ambassador asked the Foreign Secretary to ascertain if the President of the Privy Council would be prepared, when the occasion arose, to admit Italian doctors in Great Britain to reciprocity of medical practice. The Lord President of the Council, in laying these documents before the General Medical Council, informed that body that her Majesty's Government would, at the proper time, recommend her Majesty to apply Part 2 of the Medical Act to Italy.

Mr. HORSLEY urged that the Privy Council were proposing to give away all the privileges of practising in Great Britain to Italians, whilst the Italian Govern-



MR. VICTOR HORSLEY.

ment in return only proposed to give British practitioners the privilege of practising among foreigners in Italy. That seemed to him to be a rather inequitable proceeding, and one which he did not think the Council would accept. He therefore moved a resolution to the effect:—

"That it be respectfully represented to the Privy Council that the application of Part 2 of the Medical Act of 1886 to Italy at present would not provide the basis of equal reciprocity of practice between the United Kingdom and Italy, as suggested in the despatch from Her Majesty's Ambassador at Rome of April 14, 1900."

Sir JOHN BATTY TUCKE, in seconding the motion, said he considered this the most important and the most serious question in connection with registration which had ever come before the Council. The possible consequence of it was that Great Britain would be flooded with Italian practitioners over whom the Council would have practically no control. The alteration proposed was in the interests of some 35 or 40 practitioners in Italy, and it was possible that it would result in a gross injustice being done to the members of the medical profession in this country, besides seriously complicating all the medical arrangements.

Dr. MCVAIL, Mr. FOMES, and Dr. MACALISTER all concurred in the view that it would be unwise for the Council to offer any advice to the Privy Council on the matter, as such advice had not been previously tendered, and was not asked on the present occasion.

Mr. BROWN, speaking in support of the motion, said the application of Part 2 of the Medical Act, 1886, to Italy would undoubtedly result in Italian practitioners coming to this country in large numbers.

Sir CHRISTOPHER NIXON said that it would be giving privileges to Italians who came over here without the Council's having any control over their practice or their education, or of the bodies from which they derived their diplomas.

Dr. GLOVER suggested that the Council should urge Her Majesty's Government to use its influence with the Italian Government in any legislation on this subject to make reciprocity complete in Italy.

Sir WILLIAM GAIRDNER thought from the wording of Part 2 of the Medical Act that it conferred on the Privy Council absolute power to overrule the decision of the General Medical Council if they thought the interests of the country at large were prejudiced. The object of the intended legislation he observed, was to give patients, within certain limits, the power to see any medical man they liked in this country, and they could not expect the Privy Council to be hemmed in by questions of expediency and detail as to whether Italy gave us exactly the same privilege.

Sir DYCE DUCKWORTH congratulated the last speaker on having taken the question out of the region of trade-unionism into which it had fallen. It was not, he added, a question of relief for some 35 or 40 English medical men in Italy. It was a question of the relief of many Englishmen who resorted to Italy for the sake of health, and who preferred to be attended by English medical men. He did not think there was anything to tempt Italian practitioners to come to this country, and in any case the matter would remain within the discretion of the Council.

Dr. MCVAIL moved, and Dr. HERON WATSON seconded, an amendment to the effect that it was inexpedient to offer any opinion; but the amendment was negatived.

Mr. HORSLEY's motion was then put and carried by 15 votes to 10.

Dr. GLOVER moved, and Sir CHRISTOPHER NIXON seconded, a resolution to the effect that Her Majesty's Government be urged to use its influence with the Italian Government to secure for British practitioners in Italy full privileges of practice. The motion was lost.

The closure of the debate was moved by Dr. PYE-SMITH, seconded by Sir DYCE DUCKWORTH, as follows:—"That the Council do now proceed to vote on the motion."

The closure, on being put from the chair, was carried, and the original motion was thereupon put and lost.

The Council then adjourned.

SEVENTH DAY.—TUESDAY, MAY 29TH, 1900.

The Council sat for some time *in camera* to consider "an important communication" which had reached the President. On strangers being readmitted, the President announced that the following resolution had been passed:—"That, having regard to the duties performed by the Irish Branch Council and to the funds at its disposal, it is necessary, for the purpose of the due execution of the Medical Acts, that the General Council should, as part of its expenses, contribute to the income of the Irish Branch Council the sum of £500 in aid of the expenses of the Branch Council for the year 1900."



THE PRESIDENT.

THE RECIPROCITY QUESTION.

The memorandum on reciprocity of medical practice in relation with foreign countries, as revised by the Executive Committee, was entered as an appendix to the minutes, and after some discussion as to the desirability of the Council's accompanying the memorandum by a French translation. An amendment hostile to the French counterpart having been put to the vote and lost, the memorandum was approved for issue as one of the Council's publications.

DENTAL EDUCATION.

The Dental Education and Examination Committee, reporting upon an application from the Dental Board of Victoria for full recognition of its diploma as entitling its holder to registration in this country, stated that a fresh set of regulations came into force in May, 1899, and it was under these that the present application for recognition fell. These new regulations in certain respects required less of the student than the old ones, and the curriculum exacted fell in some particular far short of our own on the general medical side of the work. The regulations were in several respects a distinct falling off from those previously in force, judged from our standpoint. Were a diplomate who had obtained his qualifications under these rules to apply to the English college for admission to examination, and to be required before admission to examination to make up the subjects which would render his curriculum the equivalent of our own, he would have a good deal to attend. This did not apply to the special dental work, which was sufficient. In these circumstances, the Committee regretted that they could not advise that the request for recognition for registration be acceded to.

On the motion of Mr. BRYANT, seconded by Mr. TOMES, it was resolved "That the Council is unable to recognise the diploma of the Dental Board of Victoria as entitling its holder to registration in the Dentists' Register of this country."

A report bearing upon a proposition of the Royal College of Dental Surgeons, Ontario, that a measure of reciprocity in the matter of dental degrees should be instituted between that province and Great Britain was

then considered. The Committee explained that the scheme proposed was that on either side the preliminary examination, apprenticeship, and curriculum of the other be accepted, but that, prior to admission to examination, an attendance during the last year be required in the country in which the candidate sought examination. This did not apply to students, but only to those who had already obtained their qualification in their own country. The curriculum of the Ontario College only took three and a half years as against our four, but the additional year attended here would bring up the total to four and a half. This being the case it became a question whether, whilst one year was required of the Canadian diploma for admission to examinations here, bringing his total curriculum up to four and a half years, a somewhat shorter period—namely, a half year—should suffice in the case of a British graduate applying for examination in Ontario, which would bring his total also up to four and a half years. Upon the whole, the diploma of Ontario appeared to be of a high character, and, should the several British licensing bodies, with whom the decision must rest, take a favourable view of the application, and consider that the requirement of general equivalence to their own curricula was adequately secured by the means proposed, the Committee thought that the General Medical Council need offer no objection. The Committee recognised the desirability of acceding, if possible, to a reasonable proposition from one of our colonies.

It was resolved, on the motion of Mr. BRYANT, seconded by Mr. TOMES, to forward a copy of the report to the various licensing bodies.

MEDICAL AID ASSOCIATION COMMITTEE.

This Committee having considered certain communications referred to them by the Executive Committee on the subject of medical contracts, in which the question of canvassing arose, recommended that the gentlemen forwarding the communications be informed that in any given case where the General Medical Council was desired to take action, facts and evidence of the implication of the particular registered practitioner complained of would have to be furnished by the complainants in a statement attested by affidavit.

The report was approved without discussion, and the following further interim report was received and entered on the minutes.

It sets forth that the Committee have held a conference with four members of a Committee of the Council of the British Medical Association on the subject of the formation of a Conjoint Board for the promotion of a better understanding between the medical profession and the friendly societies. After a full and free discussion of the many points of difficulty in establishing a Conciliation Board, the deputation stated that they would report to their Council the result of the meeting, and the hope was expressed that at the forthcoming meeting of the Association, in August, the Association would be able to report its definite conclusions on the subject to the General Medical Council.

The Council then adjourned.

EIGHTH DAY.—WEDNESDAY, MAY 30TH, 1900.

The first item on the programme was a motion by Mr. GEORGE BROWN, having for object to convey to every registered practitioner an intimation that the Council strongly disapproved of their associating themselves with medical aid associations which systematically practise canvassing and advertising for the purpose of procuring patients.

After a brief discussion, Mr. Brown withdrew the motion.

REPORTS ON EXAMINATIONS OF THE APOTHECARIES' HALL, DUBLIN.

SIR DYCE DUCKWORTH moved the reception of reports from the Examination Committee on the inspection of the examinations of the Apothecaries' Hall, Dublin, held in October, January, and April last. The reports showed that the examinations were conducted excellently and that the inspector was perfectly satisfied, but the Committee wished to direct the attention of the Council to

the fact that most of the candidates coming up for examination to that board had already passed the whole or parts of their previous examinations, even in single subjects, before other boards, sometimes in other divisions of the kingdom. This method of proceeding to a diploma could not, he thought, be approved.

Mr. BRYANT seconded the motion, and after an abortive amendment brought forward by Mr. TICHBOURNE had been withdrawn, an amendment proposed by Sir JOHN BATTY TUKE that the reports be received and approved, with the exception of the qualifying paragraphs relating to the candidates' method of proceeding to complete their examinations, was agreed to.

On the motion of Sir DYCE DUCKWORTH it was resolved: "That the registrar be instructed to inquire of the various examining boards what evidence they require to be produced by candidates who claim to be exempted from examination in particular subjects on the ground that they have already passed in these subjects before other licensing bodies."

INSPECTION OF EXAMINATIONS.

SIR DYCE DUCKWORTH then brought forward the recommendation of the Committee in favour of beginning another cycle of inspections of final examinations during the present year and authorising the Executive Committee forthwith to make arrangements accordingly.

Dr. GLOVER wished the word "forthwith" to be deleted, but he was overruled and the motion agreed to.

REPORT ON ADMISSION OF FOREIGNERS TO QUALIFYING EXAMINATIONS.

SIR JOHN BATTY TUKE brought up a report by the Education Committee upon a reference to them as to the circumstances in which at present foreigners obtained exemption from some of the conditions of education and study required by certain of the qualifying medical corporations under the curriculum determined by the General Medical Council. The view was expressed that no specific case of inequality of conditions as between foreigners and British subjects had been brought under their notice, and should any such be reported, the matter would be brought to the notice of the licensing body concerned for explanation.

The Report was received and adopted.

Reports from the Public Health Committee, the Student's Registration Committee, and the Companies' Act Amendment Bill Committee were received and entered on the minutes.

APPLICATION FOR REGISTRATION.

On the recommendation of the English Branch Council Mr. William Raitt Scroggie, M.R.C.S.E., L.R.C.P. Ed., was admitted to registration.

WARNING TO ADVERTISING DENTISTS.

SIR DYCE DUCKWORTH moved that a copy of the resolution in respect of advertising adopted by the Council on May 20, 1894, be issued to every dentist whose name was on the Dentists' Register. That resolution set out that the issue of advertisements of an objectionable character, and especially of such as contained either claims of superiority over other practitioners or depreciation of them, might easily be carried so far as to constitute infamous or disgraceful conduct in a professional respect.

Mr. TOMES seconded the motion, which after some discussion, was carried.

REPORT OF EDUCATION COMMITTEE.

SIR JOHN BATTY TUKE brought up the report of the Education Committee on the question of raising the standard of preliminary education. Appended to the report was a joint report from Mr. Sharpe, Dr. McGrath, and Professor McCormick, setting out in full their reasons for the conclusions they had arrived at with regard to the adoption of the senior and higher-grade standard of preliminary education, together with a separate report from each of these experts on special points connected with the examinations of his division of the United Kingdom. Ample grounds were given, the committee stated, for the conclusion that it was impracticable in the existing conditions to require of all intending medical and dental students the standard of general

attainments represented by the so-called senior and higher-grade examinations. A substantial advance on the present requirements could, however, be made by insisting on improvements in the character and stringency of those "junior" examinations which could be directly influenced by the council, and in the case of the others by requiring that candidates offering the corresponding certificates should have obtained a higher standard than that of a simple pass. Detailed suggestions were offered which the committee commended to the favourable consideration of the Council. A question which appeared to demand a definite answer on the part of the Council was whether the time had not come for fixing a limit of age below which an applicant should not be allowed to be registered as a medical or dental student. The Committee proposed that for the present the age should be sixteen, and at a future time it might be advisable to raise it to seventeen.

Sir JOHN BATTY TUKE then moved the adoption of the first of the Committee's recommendations, which fixed the age limit for registered medical and dental students at sixteen from and after January 1, 1902.

Dr. MACALISTER seconded the motion, which was agreed to.

Sir JOHN BATTY TUKE then moved that the following recommendation of the Committee be adopted:—"That the Education Committee be authorised to take all needful steps to give effect to the recommendations and suggestions for the improvement of preliminary examinations contained in the appended joint report of the expert advisers, and to report from time to time to the Council thereupon."

Dr. MACALISTER seconded the motion, which was ultimately agreed to, and the thanks of the Council were voted to the experts named.



THE NEW KNIGHT.

REPORT OF PHARMACOPEIA COMMITTEE.

Dr. MACALISTER moved the adoption of a report from the Pharmacopeia Committee which stated that a communication from the Privy Council, forwarding a copy of a note addressed to the Secretary of State for Foreign Affairs by the Belgian Minister on the subject of a proposed international Pharmacopeia limited to drugs of a drastic nature, had been referred to this Committee by the Executive Committee. The Committee recommended the Council to reply that, should an international conference on the subject in question be arranged, the Council would be prepared to appoint representatives to participate in it, and to authorise the President to appoint one or more members to act as delegates. Another meeting of the conference of members of the Pharmacopeia Committee with representatives of the Pharmaceutical Society of Great Britain and the Pharmaceutical Society of Ireland had been held, and on its recommendation certain questions of a pharmacological and pharmaceutical nature had

been referred to experts for further investigation and report. Communications had been opened with the United States authorities with a view to bringing about greater uniformity in the official preparations contained in the British Pharmacopeia and the United States Pharmacopeia respectively; and it was hoped that by mutual concessions important approximations and assimilations in the contents of the two works might be ultimately secured. Further communications had been received with reference to the Indian and Colonial Addendum, and important suggestions from Canada had been considered by the Committee in detail. A report on progress was annexed. It was hoped that the Addendum might be authorised for issue by the end of the year. By the efforts of Dr. Leech a valuable collection of British and foreign works bearing on the history and development of the Pharmacopeia had been collected and deposited in the Council's office.

The report was adopted, and the Council then adjourned.

NINTH DAY.—THURSDAY, MAY 31ST, 1900.

THE ROYAL COLLEGES AND THE COUNCIL.

Dr. MACALISTER brought forward the report of the Education Committee comprising certain communications forwarded by the Royal College of Physicians of London and the Royal College of Surgeons of England with reference to the Council's new regulation for the registration of medical students. The licensing bodies had been informed that schools for boys and girls were not intended by the Council to be regarded as institutions at which the first of the five years of medical study might be spent, and the Council would require that before registration was effected a student should have commenced medical study at a University or school of medicine, or at a scientific institution recognised by one of the licensing bodies and approved by the Council. The new regulation which was framed in support of this came into force on January 1st last. The Royal College of Physicians of London and the Royal College of Surgeons of England, alone of all the licensing bodies, had taken objection to the regulation and had adopted a resolution affirming that they failed to recognise any authority under the Medical Acts in virtue of which the Council could impose the conditions formulated in the regulation, and declining to recognise the requirement that scientific institutions where medical study was commenced should be approved by the General Medical Council. The Committee of Management of the Examining Board of the Royal Colleges, after a conference between its representatives and the President of the General Medical Council, had stated in a report of the two Colleges that they were unable to discover any grounds for altering the decision of the Royal Colleges, and appended a memorandum setting forth the legal and other grounds for the view they had taken. The report of that committee had now been adopted by the Royal Colleges, and constituted their answer to the Council. One of the questions for the consideration of the Council was whether it was in the interest of medical education generally that the first year of medical study should be taken at ordinary schools of higher elementary or of secondary education. The Committee maintained their opinion that ordinary school education should be completed before the five years' medical curriculum was entered upon, and they believed that the regulation in question was the simplest practical method of ensuring this. They therefore recommended that the Council should continue to adhere to it. They further recommended that the question of the power of the Council to impose their conditions, and the right of any one of the licensing bodies to require the Council to enter on the Students' Register the name of a student who had not fulfilled the conditions prescribed by the Council, be referred to the Council's legal adviser. Dr. MACALISTER, in moving the adoption of the first recommendation, pointed out that the Council asked that medical students should do two things—first that they should have passed a preliminary examination which the Council

considered sufficient, and, secondly, that they should *bona fide* have commenced the five years' course of medical study. The motion was seconded by Dr. PAYNE.

Mr. BRYANT said that the Council was not in a good position to form an opinion on the question until members had read the memorandum forwarded by the Committee of Management of the Conjoint Examining Board. He accordingly moved the adjournment of the debate until the next session, to give members an opportunity of studying that document.

Sir DYCE DUCKWORTH seconded the amendment, which was adopted after a brief discussion.

The President was requested to obtain the opinion of the Council's legal adviser upon the matter before the next session of the Council; and certain individual applications for registration which had been received by the registrar since January 1st, were referred to the Students' Registration Committee as exceptional cases to be dealt with on their individual merits.

THE MATRICULATION EXAMINATION OF THE UNIVERSITY OF BIRMINGHAM.

Dr. MACALISTER brought forward another report of the Education Committee in respect of an application to the Council for the recognition of the Matriculation Examination of the University of Birmingham as a preliminary examination admitting to the Students' Register. The Committee state that the proposed examination is not inferior in its scope to those which are already recognised by the Council; and recommend that the examination (the certificate to include all the required subjects at one time) should be added to the list of recognised preliminary examinations.

The motion was agreed to *sem cos.*

THE JERSEY MEDICAL ACT.

Dr. MACALISTER then read a report of the Education Committee on the legal aspect of the Jersey Medical Act embodying counsel's opinion thereon. Counsel pointed out that one of the principal objects of the enactment appeared to be to prevent unqualified persons from practising medicine and surgery in the island. The classification of titles to practise in the island was not altogether convenient, for if a person whose name had been removed from the *Medical Register* for infamous professional conduct was the holder of a diploma which could not be taken away from him by the medical corporation which granted it, such a person might, under Article 2, obtain permission from the Jersey Court to practise in the island. Counsel therefore suggested that Article 2 should be altered with a view to meeting the difficulty.

The report was approved, and the President was requested to communicate to the Lord President of the Privy Council the Committee's observations on the Act, and to ask on behalf of the General Medical Council that they might have his Grace's consideration.

THE SOCIETY OF APOTHECARIES AND THE TITLES "PHYSICIAN AND SURGEON."

Mr. BRYANT presented a report from the Apothecaries' Society Letter Committee upon a letter from Mr. J. R. Upton, clerk to the Society of Apothecaries, as to the use of the titles physician and surgeon. The Committee declined to recommend that the funds of the General Council should be employed to guarantee, in conjunction with the Society of Apothecaries, the expenses of the plaintiff and defendant respectively in a test case to determine, by the Court of Appeal or the House of Lords, whether a licentiate of the Society of Apothecaries was entitled to describe himself as physician or surgeon.

The report was adopted after a brief discussion.

COUNCIL FINANCE.

It was reported that the income of the general and branch councils for the year ending December 31st last was £10,405, and the expenditure for the same period £10,677.

The various committees were afterwards appointed, and Mr. Allen was re-elected the general registrar for the ensuing year. After the transaction of other business, the proceedings concluded with a vote of thanks to the President.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, June 2nd, 1900.

At the Congress of German Surgeons, Hr. Frendenberg, Berlin, read a paper on

BOTTINI'S OPERATION

for enlarged prostate showing a prostate incisor devised by himself and Dr. Bierhoff. He had now performed Bottini's operation 77 times on 61 patients, and had formed a favourable opinion of it. But he must remark that it was not so free from danger as he had at first thought; 683 cases were already described, of which 38 ended fatally. Taking off nine cases in which it was questionable whether death was due to the operation, the mortality would be 44 per cent. In the successful cases there was a complete cure in two-thirds, and improvement in the remaining third. It was not yet decided whether the operation should be performed with the full or the empty bladder. Bottini recommended operation with the empty bladder, but the operator had found transverse folds in one case when the bladder was empty, which had been cut by the incisor, in consequence of which he had filled the bladder with boracic solution before the operation, and afterwards he had filled it with air pumped in. Before cutting, the position of the incisor must be ascertained from the rectum. As regarded after treatment, the speaker had not at first placed in a catheter a *demeure*. As, however, a number of patients could not empty the bladder at once, he had used it when the hæmorrhage was free, when there was suppuration, and when catheterisation was difficult, and it had to be frequently. He would not be content with half results, but would repeat the operation if success was not complete. The causes of failure were not sufficiently deep in long incision. Incisions that were too long were naturally dangerous. Recurrences were very rare, and scarcely ever occurred where the primary result was satisfactory.

In order to do the operation under the guidance of the eye, Wossidlo had combined the incision with the cystoscope. The speaker had replaced this by an instrument that worked on the prostate. The calibre was rather larger than the other. The instrument was shown along with two successful cases operated on two-and-a-half and three years respectively.

Hr. Wossidlo remarked that the new model had the advantage that it could be taken to pieces, and thereby be kept entirely free from germs.

Hr. V. Frisch (Vienna) was of opinion that the results of Bottini's operation were by no means so important, and that the procedure was not reliable. We did not know in advance whether it would succeed or not, nor did we know how it succeeded. The instruments presented were worthless, as we could only see through the cystoscope at the commencement of operation, and afterwards the field of vision was obscured by blood.

Hr. Jaffé, Posen, had twice seen free hæmorrhage after casting off of the slough. He would advise that all other means should be tried before resorting to Bottini's operation. The results in these bad cases were not very good, only one fifth to one fourth were cured or improved.

Hr. Troge had tried it in four cases, and had been satisfied with the results.

Hr. Kummell, Hamburg, thought the operation was gaining recognition more and more, and properly so, for the results were often very marked. It was easy of performance, did not require narcosis,*but a necessary condition of success was a deep and extensive incision.

Hr. Zucherhandl, Vienna, thought the instrument required further improvement.

Hr. Brentano, Berlin, showed a patient on whom operation had been performed for

NECROSIS OF THE PANCREAS.

He attributed the necrosis to perforation of an ulcer of the stomach.

Hr. Bessel-Hagen showed a boy of 13, who, in April, 1899, after an attack of influenza, had pains in the stomach, with vomiting; the upper part of the abdomen swelled, and the patient emaciated. Examination showed an immovable swelling on the left side, that disappeared under the ribs, with fever and quickening of the pulse. The cachectic condition demanded some interference. Laparotomy was performed in the middle line; the projecting stomach showed through the opening and encircled a cyst except near the vertebral column. It was firmly attached to it, so that separation was not possible; there was a moderate amount of exudation in the peritoneum. Direct entrance into the cyst could only be made near the vertebrae, but this was not made on account of the possibly infectious nature of the contents of the cyst. The speaker therefore decided to make the opening through the stomach, passing through both anterior and posterior walls. After emptying the cyst it was sutured to the abdominal wall just below the tenth rib, which was resected for the purpose of draining. The stomach wounds were closed by suture. A favourable recovery took place. A small opening, however, remained in the posterior wall of the stomach, but some stomach contents passed into the cyst only, so that no peritonitis took place. Two months after the operation the cyst had disappeared, and the boy had now increased 10 kgrm. in weight.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, June 2nd, 1900.

SUB-ACROMIAL DISLOCATION OF THE HUMERUS.

At the "Gesellschaft der Aerzte" this week Bum showed a boy with congenital dislocation of the humerus under the acromion, both the bones of the forearm being also dislocated forward at the elbow-joint. From the history of the case, assisted by the Röntgen rays, he was convinced that the primary cause was a paralytic intra-capsular dislocation, probably caused by the pressure of instruments at birth.

PERFORATION OF THE INTESTINES.

Schnitzler exhibited a patient over whose abdomen a 34-kilogram cask had rolled. Notwithstanding the few indications of rupture a diagnosis was arrived at from his having only once vomited, with almost no pain or pressure about the abdomen. Laparotomy was performed within twenty-four hours of the accident, yet there was already purulent peritonitis present around a hole in the bowel about the size of a bean, in the region of the ileum. The opening was closed, the peritonea

cavity washed out with a warm saline solution, and drainage applied, with excellent results.

In another case, where a workman was breaking iron with a hammer, a fragment penetrated the abdomen below the umbilicus, wounding the small intestine.

He attributed recovery in this case to the prompt performance of laparatomy.

ECHINOCOCCUS OF THE LIVER.

Meinlechner next introduced a man with great swelling of the abdomen. He first observed the enlargement about eighteen years ago, and it had ever since gone on gradually increasing. The tumour, on palpation, had a vertical median depression which led Weinlechner to believe that both liver and spleen were affected with the cysts. He was in doubt which method to follow in the treatment; whether by extirpation of the cysts, or destruction by iodine injections.

FIBROMA MOLLUSCUM.

Spiegeber showed a patient covered from head to foot with fibroma mulloscum ranging from the size of a hazel nut to that of a pea.

THE CURRENT OF AIR IN THE NOSTRILS.

Réthy next related to the Society a record of experiments which were both novel and ingenious. The pathological changes in the nose have been much discussed of late in respect of their origin, some attributing first changes to rapid changes of temperature, others to fomites, irritants, or toxic agents. Réthy believed that the current impinging on different portions of the mucous membrane continuously was one of the determining causes of polypi, warts, adenoids, and vegetations generally. To demonstrate this theory Réthy first obtained wax impressions of healthy nostrils and then pathological ones. From these models were constructed for his experiments with litmus, ammonia, and tobacco vapour.

In the normal healthy nostril he finds that the air when inspired, impinges first on the outer side of the orifice of the nostril at right angles, on rebounding from which it strikes the septum which guides it into the vault about the anterior portion of the middle turbinated bone, where the current of air is broken up into an ascending and descending current, which are deflected posteriorly to discharge into the pharynx.

The current is not altered by the direction of the external movements or the size of the external orifice, but, on the contrary, by the form of the orifice and the configuration of the surroundings. The pathological changes are in proportion to the deflection of the natural current. Any hypertrophy of the middle turbinated bone conducts the current backwards without other changes; and if only the lower turbinated bone be affected the normal condition of the nose is but little affected. If the middle turbinated bone become so large as to require resection it must be remembered that this operation will not alter the direction of the current. The same may be said of the lower turbinated bone when removed. The feeling of heat and dryness will exist after the removal as before, also stenosis will have the same feeling after operating in the same manner.

ALLOXURINE BASIS.

Jolles demonstrated an easy method of determining quantitatively the urea as well as the "purin" basis in the urine by depositing with a silver magnesium salt,

then oxidising the precipitate, and determining the total amount of nitrogen with the azotometer. A similar quantity of urine is precipitated by acetate of ammonia. The difference will correspond to the quantity of alloxurine, xanthin, hyoxanthin and adenin. The xanthin and hypoxanthin being derived from the cell nuclei will be found the most useful in diagnosis. He referred to two cases of cancer of the stomach, typhoid, pernicious anæmia, and leucocythæmia where this constituent was of special value in diagnosis.

Continental Notes.—The Savoy Spas.

[FROM OUR OWN CORRESPONDENT.]

IV.—BRIDES AND SALINS-MOUTIERS.

THE Saline Bath Establishment is at the village of Salins-Moutiers, about two miles down the valley from Brides (by a road of singular beauty), and one mile from the very ancient town of Moutiers. Brides is quite a modern village, but the records of Moutiers extend through all historic eras, and its traditions run well into mythological ages. These traditions say Hercules (of Gaul not of Greece) came frequently to renew his strength in these potent springs; and the records relate that when Hannibal surprised and captured Moutiers, in a sanguinary night attack, it had long been a prosperous city. Vestiges of the Carthaginian General's costly march through the Tarentaise Alps are yet visible around Moutiers. He brought thirty-seven elephants and 62,000 soldiers into the Tarentaise region; but only carried with him one elephant and 28,000 soldiers down the Italian side of the Alps to Aoste. Our losses in South Africa are wonderfully light in comparison with such old-time campaigns.

Salins-Moutiers is situated 1,500 ft. above sea-level. Its mineral waters rise on the right shore of the Doron river, at the foot of a large chalk rock 25 ft. below the surface of the ground. They spout by several openings or jets, and are collected into two subterraneous reservoirs known as the *grande* and *petite* sources. They are led by canals from these reservoirs to the Thermal Establishment on the other side of the river.

Their flow is enormous, averaging over 1,100,000 gallons every twenty-four hours. Their specific gravity is 2 degs. Baume, and invariable temperature 95 degs. to 96 degs. Fahrenheit. They contain 16 grammes of salts per litre, and all analyses show large percentages of chlorides, sodium, iron, and some iodine, arsenic, magnesia, and lithia.

These saline waters are used for drinking, but their principal use is in baths, douches, pulverisations, and irrigations. The Establishment contains a variety of baths and douches, and a speciality of family bathing rooms. Another arrangement enables internal irrigation to be used during the ordinary baths.

The copious output of the Salins waters enables the Establishment to give continuous currents to both the ordinary and the swimming baths. Owing to the free and incessant escape of carbonic acid gas, the body while in the bath becomes covered with tiny bubbles; and the patients frequently feel reluctant to leave a bath which they find so soothing and refreshing.

The saline waters can be drunk pure, or mixed with

milk or syrups. Their taste is at first rather nauseous; being bitter and salty. In small doses they excite and stimulate the appetite—assist in the assimilation of food, and do not disarrange in any way the digestive organs. Children may so take them quite safely, however delicate; but in large doses they increase the flow of saliva and provoke plentiful evacuations. They should thus be taken only under medical advice and supervision. (At Brides are several able and experienced physicians; English, and French speaking English).

The waters are originally limpid. In contact with the atmosphere, they deposit an ochreous mud (rich in salts of arsenic and iron), which is beneficially used for various affections.

Taken in baths the waters of Salins-Moutiers stimulate the skin and increase its functional activity; they possess a tonic action, reconstituent and resolutive; most valuable in all scrofulous troubles; especially in rickets, stoppage of growth, anæmia, and chlorosis. Their elevated temperature, concentrated mineralisation, quantity of gas in solution, and continuous copious output, place them in the first rank of saline waters.

Dr. P. Delastre (of Brides), writes:—"Tonic and stimulating in the highest degree the Salins-Moutiers waters develop the muscular tone; and specially affect the circulation, which is gradually quickened, while the heart is strengthened and beats with renewed force. Their action is most remarkable on the glandular system; being very advantageous to scrofulous and lymphatic patients. Glandular swellings, diseased joints of every kind, fibrous growths, and feminine troubles yield admirably to our Saline waters. We do not pretend to cure tumours; but, when not malignant, these certainly become smaller under our treatment. We have certainly obtained relief from pain, from hæmorrhage, and many other attendant symptoms."

Brides and Moutiers are easily accessible from Paris by the direct trains (*via* Culoz and Aix-les-Bains) to Modane, a branch line to Albertville and Moutiers leaving the main railway at St. Pierre d'Albigny Junction.

Quite apart from the unsurpassed mineral waters of Brides-Salins, the proximity to Aix-les-Bains, the higher elevation, and the bracing purity of atmosphere, make a sojourn at Brides a very convenient and beneficial complement to an *Aix-cure*. Mountain scenery of every description, unexcelled in beauty or in grandeur by anything in Europe, can be found within easy walks and drives of Brides.

Health Resorts of the West of Ireland.

It has long been recognised by the profession and by the public who have sought health in the West of Ireland, that the climate presents great advantages, by reason of the mildness of the winters and the balmy warmth of the spring and summer, for people suffering from pulmonary disease. The bracing air which prevails and the absence of excessive vegetation which elsewhere renders the climate too relaxing for those who are convalescing from debilitating illnesses, such as influenza. The South-West of Ireland owes its advantages to the fact that the prevailing winds come straight from South America across the

Atlantic, receiving *en route* the warmth of the tropical sun, and also from the trend of the Gulf Stream current, which impinges on that shore and brings its quota of heat to this, the first land which it meets. Thus it happens that a residence on the bays and fiords of South-West Ireland, which are sheltered from the north and east winds, is universally recognised as one of the most certain means of relief from the diseased conditions to which we have referred. One of the most favourably situated of these is Clew Bay, which stretches for nearly twenty miles from the headlands beyond the island of Achill up to the town of Westport, in county Mayo. On the northern side the coast line, though situated well above the water, is effectively protected from the north and east winds by a range of mountains, and the tourist standing and looking due south across the bay commands a view, about seven miles off, of a most beautiful panorama of the mountains of north Connemara, while he finds himself in a lovely amphitheatre of protecting hills. The village of Mulranny or Mallaranny (for there are half-a-dozen ways of spelling the name) is picturesquely situated at this spot, just half-way between Achill Island and Westport, and its merits as a health resort had been sung by wanderers long before any adequate steps were taken to provide the requisite accommodation for invalids or tourists. Some years ago, however, the Midland Great Western Railway Company discovered that it had within easy reach a very attractive tourist centre, and the company at once purchased a small estate on the best part of the coast, and proceeded to build a suitable hotel, now known as the Mallaranny Hotel. The rush of claimants for accommodation in the section of the house first built at once satisfied the Directors of the company that a considerable enlargement was needed, and the season after the completion of the second wing, both it and its progenitor, the first wing, were overcrowded. A third and more extensive addition has now been opened, and with its help it is believed that the demand for accommodation will be met. The house is in all respects what is described by travellers as a first-class hotel, water supply and drainage having been carefully attended to, and the whole house fitted with electric light, lifts, &c. A new feature is a very complete and handsome suit of baths within the hotel where hot or cold or spray sea water or fresh water are always available. The establishment is, moreover, situated in the middle of one of the most unsophisticated districts in Ireland, where the manners and customs, the garb, and even the language, of the natives afford subjects of interest for observers from afar. Altogether, we do not hesitate to recommend a period of residence at Mallaranny as a means of regaining health and strength.

A NEW disease, called golf-mania, is reported to be so prevalent in the United States that a judge has pronounced it to be a valid reason for divorce. A medical opinion on this new scourge has, so far, not been sought.

THE annual exhibition of medical, surgical, and hygienic appliances will be opened to-day (Wednesday) at Queen's Hall, London, W., and continued until the end of the week. Entrance is free to the medical profession.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JUNE 6, 1900.

GENERAL MEDICAL COUNCIL.

LOOKING back on the nine days' session which came to an end on Thursday last, it is difficult to realise that the results of all this discussion bear any fair proportion to the time and energy expended. There has been a long, possibly somewhat tedious, discussion on the prevention of personation which has so far produced no tangible result, certain points having been referred to the Council's legal advisers for direction. The matter is one well worthy of serious consideration, though, as one member observed, the risk of personation at examinations is possibly greater than in respect of registration, a point to which no licensing body, so far as we are aware, has as yet given any attention. We are, as a nation, very lax in matters concerning personal identification, contenting ourselves with punishing those who happen to be caught *in flagrante delicto*. As personation, it may be assumed, must necessarily be a tolerably rare offence, no great harm will accrue from a little delay in formulating a method of rendering it more difficult of accomplishment.

The hair-splitting propensities of certain members of Council found elbow room in discussing the question of reciprocity of medical practice between this country and Italy which came before the Council on certain documents forwarded by the Privy Council, presumably for information and advice. It would evidently be hardly fair to expect us to accord full rights to Italian practitioners to practise in this country in exchange for the restricted right, contemplated by pending legislation in Italy, in virtue whereof British practitioners would be allowed to practise only among their countrymen. Still, the matter is one susceptible of adjustment, and doubtless if representations were made in the proper quarter the

difficulty would disappear. With much hesitation the Council decided to call the attention of the Privy Council to the discrepancy, and we must await the reply of the Italian Government to the observations which the Foreign Office can hardly fail to make thereon. The discussions were, in the main, characterised by a narrow spirit of trades-unionism which must be deplored. It is not a question of protecting the vested interests of British practitioners against legitimate competition or of coming in aid to a few score of British practitioners in Italy. The question is one which should be looked at from a higher standpoint. We should like to see these paltry geographical distinctions swept away in favour of a true brotherhood of science. We must protect ourselves and the public against impostors and inadequately educated persons, and we must take care that foreigners, in acquiring the right to practise here, become subject to the same disciplinary rules as ourselves. Subject to the control of the Council such competition ought not to be regarded with a prejudice begotten of sordid considerations, especially in view of the fact that, as a nation, we have much to gain and little to lose by reasonable concessions. The idea that Italian practitioners are likely to "flood the country" is too preposterous to be entertained, but possibly this apprehension is really aimed at graduates of universities of countries where English is spoken. Inasmuch, however, as it rests with the Council to approve degrees presented for registration as fully equal to our own, we are not likely to suffer from downward competition.

The resolution of the Council to contribute to the income of the Irish Branch Council by an annual allocation of funds is at best but a make-shift solution of a grave and pressing question. Sooner or later the matter will have to be dealt with on a sounder financial basis, and certainly the better plan would appear to be to allocate the registration fees to the Branch Council of that division of the kingdom in which the person registering has passed the greater part, or such part as may be decided upon, of his curriculum.

The Medical Aid Association question remains to all intents and purposes *in statu quo*, but it may fairly be claimed that the matter is one which the maxim of *festina lente* is peculiarly applicable.

The perennial question of the standard of preliminary education continues to agitate the Council. A careful perusal of the report embodying the opinions of the experts still fails to convince us of the validity of the difficulties alleged to exist in the direction of raising the standard of educational requirements. We are assured that the state of secondary education in this country is such that if the senior examinations were forthwith insisted upon as the standard of admission to medical study, either the number of students would be diminished "to an indefinitely large extent" or the examiners would be compelled to a laxity of marking and a depreciation of the character of questioning which would

merely have the effect of reducing the level of the senior papers to that of the junior papers. Truly this is a very humiliating confession for the experts to make! Is it then still true, as was once remarked by a foreign visitor, that while we are fifty years ahead of the Continent in hygiene, we are fifty years behind in education? In any event the Council has allowed itself to be influenced by the report to the extent that little or nothing is to be done to raise an admittedly inadequate standard, and our claim to be regarded as a learned profession is *pro tanto* jeopardised. One regulation, not without its importance, was agreed to, viz., that after January 1st, 1902, no person will be admitted to registration as a medical student under the age of sixteen, and the hope is held out that this limit will be raised to seventeen at an early period. This will have a salutary effect in more ways than one, and in years to come we shall be spared the scandal of seeing mere boys in the wards of our general hospitals.

THE REPORT ON DUBLIN SANITATION.

THE verdict of the Departmental Commission appointed by the Lord-Lieutenant to investigate the causes of the excessive insalubrity of Dublin was delivered on the 18th ult., and is a pronouncement of extreme interest to the citizens, besides being of use as a lesson to sanitarians elsewhere. Of it we may say that, as a succinct and intelligible epitome of the causes of the excessive mortality, the Report is valuable, and no one can read it without arriving at a well-considered opinion on the subject; but as a leading light towards the fairway channel of escape from the sanitary slough of the city it is of little value, and as it offers few practical suggestions, and those which it does offer are contentious, we should fear that this report will be relegated to the same oblivion as that of a similar Commission in 1879. When the Lord-Lieutenant saw the necessity for assuming responsibility in the matter, and when the Commission itself was enlarged beyond the scope of the three or four officials to whom such investigations are usually entrusted, we were sanguine that at length something decisive might be done to level up the salubrity of Dublin to that of other similarly situated towns, but our daily perusal of the evidence submitted convinced us, shortly, that the outcome of the inquiry would be a simple reiteration of the causes of insalubrity, which every Dublin sanitarian has been well informed for thirty or more years past. The time of the Commission was largely occupied with the testimony of earnest but unpractical Dublin people, each with his own wisp of hay on his own particular horn, and also with the pretentious orations of English and Scotch civic officials, whose knowledge of the special circumstances of Dublin and of its financial capabilities was about as intimate as of those of Mafeking. The Commission learned from these latter gentlemen what they had done and intended to do with an unlimited supply of money, a code of laws applicable to every detail of sanitation and a population

of more or less law abiding and self-respecting, most of them in the enjoyment of robust constitutions and of every facility for maintaining that constitution by abundant and good food, all which information was about as useful to the Dublin citizens or to His Excellency's Commission as a review of the sanitary condition of Constantinople, inasmuch as not one of these facilities for sanitary reform exist in Dublin, and it was the special duty of the Commission to point out the methods by which Dublin, by earnest desire to amend and great exercise of patience, and an absolute determination to go through to the desired object without regard to the profits of tenement farmers, speculating builders, and trafficking corporators can safely and diplomatically proceed to achieve reform. This, we regret to say, the report of the Commission does not make any attempt to do. It opens with a detailed comparison of the *status quo* in 1879 with that now existing, and it gives credit for a material improvement in all the conditions which affect the public health, but, unhappily, it is unable to say that any reduction in the death rate has resulted therefrom, for the mortality is now as high, generally, as it was thirty years ago. We need not follow the Commission through its enumeration of the causes of insalubrity, with which every citizen has been acquainted for years past, and we pass on to the suggestion of remedies by them, which seems to us to be sadly disappointing. Such trifles as the removal of a scavenging barge a few hundred yards down the river—the fitting of lids to the dust carts—the erection of a new destructor seems to have left the Commission no breath wherewith to hold forth about the course to be adopted to mitigate the abomination of the tenement houses. We know that the Corporation has always hidden itself behind alleged insufficiency of legal powers when asked to take action, and, at this moment it is sheltering itself from criticism by the same plea, and by threatening the citizens with the penalty of having to go out into the suburbs to look for sites for houses for the very poor, to be purchased at a vast expense. The Commission has made no attempt to suggest what changes of law, if any, would be necessary to make the civic law sufficient, nor does it offer any information to indicate what sites are already available without cost; and, in fact, it is in this regard highly unsatisfactory. It has, however, promulgated one original idea, for it has proposed the annihilation of the sixteen Medical Officers of Health on whom the detection of disease and insanitation now depends, and the perpetration of a job in the appointment of a single Assistant Medical Officer of Health at a big salary. It is our unqualified opinion, that however desirable the appointment of such an officer in addition to the rest of the Health staff might be, he could in no sense fulfil the duties, even if he had the brains of Archimedes, the industry of Sisyphus, or the salary of a Lord Chancellor. We trust, and have every reason to believe, that the citizens will speedily put their feet firmly down upon this job.

ARTISANS' DWELLINGS: ARE THEY LODGING HOUSES?

A LEGAL issue of great importance to public health administration has recently been brought forward in a London Police Court. The question was raised upon a summons taken out by the Vestry of St. George the Martyr, Southwark, against a clergyman, the owner of residential buildings, for refusing to furnish certain particulars as required in the by-laws with regard to lodging-houses. This step constitutes a deliberate attempt to bring workmen's dwellings within the category of lodging-houses, so that the sanitary authority might be in a position to enforce the cleanliness of such premises, and to prevent overcrowding. The legal contention of the vestry was that the occupants of the one and two-roomed tenements in the buildings in question were really lodgers, and that each block was a lodging-house within the meaning of the Act; that is to say, it was "a house or part of a house which is let in lodgings or occupied by more than one family." It is clear that everything depends in that position upon the definition of the word house. The Act has not given a clear definition of the term, an omission which has already led to a good deal of costly litigation. The contention of the defence, on the other hand, was that in this building, although the tenement might comprise only one room, it was a separate dwelling-house, and that the occupiers were not lodgers, but "occupying tenants." Their names were on the rate-book, and although they compounded with their landlord for the payment of the rates, they were nevertheless in possession of the parliamentary franchise, and were in a similar position to the holders of West-End flats. The magistrate, Mr. Slade, in giving his decision showed that his sympathies were not altogether enlisted on the side of his judicial conclusions. He quoted from 1899 annual report of Dr. Waldo, the Medical Officer of Health for St. George the Martyr, a passage which stated that "in this parish, houses built on the so-called model or block system, and accommodating upwards of 12,800 persons, escaped the salutary provisions of the new by-laws. These dwellings, often inhabited by the uneducated and unruly poor, are for the most part badly supervised." However, as Mr. Slade pointed out, he had to follow the decisions of the judges of the Supreme Court, so that when it appeared, as in that case, that the landlord did not reside on the premises, and did not exercise any control over them, either by himself or by his servants, those premises could not be said to be lodgings in any meaning of the word. He therefore dismissed the summons, but agreed to state a case for appeal to the higher courts. There the matter rests for the present, but we venture to assert that a state of affairs has been disclosed that is intolerable. If the law is incapable of dealing with a condition of things such as here exists, then the sooner the law is altered the better for the public weal in every community. We venture to think that all candid persons must agree with that particular view when they have

heard the following brief account of this slum dwelling. During the past eight years the Medical Officer of Health for the district has officially represented these buildings as unfit for human habitation, and asked for closing orders no less than five times. On the first occasion the owner, who was said to be Mr. Smith, of South Africa, was fined £10 and one guinea costs, or one month's imprisonment for each offence. Ownership has changed hands within the last few months, so that the buildings now belong to a clergyman, and we understand that some amount of improvement has taken place in the sanitary state of the tenements. It is in buildings of this type, situated in the most densely inhabited and poor quarters of the metropolis and of the great towns of the United Kingdom, that a vast amount of overcrowding occurs. In the interests of the general community, therefore, it is absolutely necessary that they should be brought under stringent sanitary control. If it were only on the one point of the liability to the spread of infectious diseases, the contention of the Southwark Vestry would be more than amply sustained. What is the good of an elaborate system of notification, isolation, and disinfection if fever is able to run like wildfire through one of these human hives? Should the present case be thrown out on appeal, as seems more than likely, the most hopeful course will be for local authorities throughout the country to press for an amendment of the existing law, so that tenement buildings may in future be regarded as lodging-houses. The increased control that would be afforded to the local authorities by such an extension of the principle underlying the Act may be gathered from another recent Southwark case, in which the owner was summoned for refusing to furnish the following particulars:—"The total number of rooms in the house, the total number of rooms let in lodgings or occupied by members of more than one family, the manner of use of each room, the number, age, and sex of the occupants of each room used for sleeping, the Christian name and surname of the lessee of each room, and the amount of rent or charge payable per week by each lessee." To ask that, may be, as the magistrate remarked, inquisitorial; but under certain circumstances, especially in dealing with slum property, it is necessary to be inquisitorial.

Notes on Current Topics.

The Cortical Centre of the Sexual Instinct.

THE position of the Cortical Centre of the Sexual Instinct is the subject of an article by Dr. R. J. Styll in an American contemporary. The author concludes that it is located in the angular gyrus of the frontal lobe of the cerebrum, and his grounds for it are as follows:—On the evening of November 22nd, 1879, a mulatto girl was murdered at Fortress Monroe by a German. The murderer was a healthy, well-developed man, five feet eight inches in height, and of more than average intelligence. The body of the victim was discovered lying on a bed

perfectly naked, with an incised wound five or six inches long in the right groin, through which the intestines, ovaries, and Fallopian tubes had been extracted. The intestines had been partially torn up and scattered about the room, some in a bucket, some on a trunk, and other portions about the room in various places. The ovaries and tubes were not found, and it is presumed they were carried away by the murderer, who committed suicide while in prison. On a post-mortem examination, made by Dr. Christian, there was found a small cyst, half-an-inch in diameter, with distinct walls and containing fluid. It was situated on the right hemisphere, in the anterior part of the angular convolution. This, Dr. Styll considers, was a case of *paræsthesis sexualis* with anthropophagous practices in a man who could not by any stretch of sympathy be pronounced insane. And he adds:—"The cyst was just at the point best situated to interfere with and misdirect any impression and stimuli on their way to the central reflex centres in the spinal cord from the cerebral cortex of the angular gyrus and neighbouring convolutions; and the fact that the man was perfectly healthy, and all his mental and somatic functions, except those dependent on the sexual nervous mechanism, were normally performed, goes far to point to the angular gyrus as the cortical centre for the sexual instinct. This suggestion is further strengthened by the fact that the angular and supra-marginal gyri are the parts usually involved in cases of *prosoopia*."

A Suspended Committee.

THE principle of postponing the discussion of any given matter *sine die* by handing it over to the tender mercies of a special committee is by no means confined to Parliament. Few medical men probably realise to how great an extent the practice is carried on amongst their own societies. Perhaps we may be allowed to quote a single case in point from the recorded history of the Royal Medical and Chirurgical Society of London. So long ago as 1889 that distinguished body decided, with Sir William Sieveking in the chair, that it would be desirable to appoint a committee to investigate the claims of the various balneological and health resorts in the United Kingdom. That committee still exists, under the chairmanship of Dr. Ord, who stands at the head of an imposing array of no less than twenty-one well-known members of the profession. In this instance, however, it is a case of *parturiunt montes*, for, so far as we have been able to learn the only work ever issued by the committee is a compilation of about 600 pages published some years ago by Macmillan under the title of "*Climates and Baths of Great Britain*." That there was abundant scope for such an inquiry is amply proved by the flourishing condition of the British Balneological and Climatological Society. There is another committee appointed by the Medico-Chirurgical Society to investigate suspended animation in the apparently drowned, but we do not recall any pub-

lished results hailing from that direction. If such committees are allowed to languish out of existence it is better they should not be appointed at all, as such a step merely helps to shelve the question indefinitely and to discourage individual investigations.

The Police and Suicidal Patients in Hospital.

AN issue of considerable interest to the police, the public, and the hospital authorities in all parts of the United Kingdom has been recently raised in Worcester. It appears that the chief constable of that city refused to permit the watching by a constable of a patient who had attempted suicide. This refusal opens up a number of more or less complicated legal questions as to the incidence and the amount of responsibility in this distressing class of cases. Hitherto it has been the universal custom under such circumstances for the police to furnish night and day attendance at the bedside of the patient until his discharge from hospital. Technically, if the Chairman of the Worcester Infirmary Committee be right, suicide is a misdemeanour and not a felony, so that until the would-be suicide has been charged he is not actually in the custody of the police. The logical outcome of that proposition is crystallised in the Chairman's motion, "That the Committee will continue to receive, as urgent, cases of attempted suicide, and give them all necessary treatment, but that the Watch Committee of the City adheres to its resolution not to be responsible for the safe charge of such patients while in the Infirmary, this Committee claims the right to consider under what conditions such patients shall remain or shall be discharged." If the police deliberately intend to take up the position indicated by the Worcester Chief Constable they must not be surprised if they have in future to remit all cases of attempted suicide to the prison or the workhouse infirmary. It is to be regretted that the Worcester Chief Constable cannot find a more profitable outlet for his restless official ingenuity in lightening the duties of the force under his command.

Mice in Bottled Beer.

FROM time to time cases occur in which the presence of mice in bottled ale or stout leads to subsequent legal proceedings on the part of irate customers. The usual result of drinking beer contaminated in that particular way is sickness, vomiting, raised temperature and shock; that is to say, the symptoms are those of ptomaine poisoning. Last week an action of this kind was brought in the Poole county court, by a butcher's assistant, who drank a portion of beer from a bottle which was found to contain three mice. He was ill for several days in consequence, and brought an action for damages against the grocer who sold the stuff. The county court judge awarded him the sum of £7 10s., which was not by any means an excessive sum under the circumstances. Presumably, the mice get into the bottle before the ale is put in during the

process of bottling, but it is supposed workmen sometimes insert the mice in order to take a private revenge upon their employers. In any case the legal aspects of the matter are a little complicated. It is clear that with a little ingenuity an unscrupulous person could fabricate a case that it would be almost impossible to disprove. Another point is the legal responsibility of the vendor, as against the brewer who originally bottled the beer. In the present case the decision appears to have been accepted without demur by both parties to the suit. Few persons who drink bottled ale would be likely to examine systematically every bottle of their favourite beverage to see whether there was—as the newspapers are wont to say—too much body in the beer.

Some "Signs" in Appendicitis.

IN the course of a series of clinical lectures on the various forms of intra-abdominal suppuration, now in course of delivery at Westminster Hospital, Mr. Tubby called attention to the importance of certain "signs" in the diagnosis of appendicitis. In his opinion the most common sign is rigidity of the abdomen. As a rule the whole abdomen is distended and somewhat rigid or tympanitic; later on, at the second or third day, local rigidity and tenderness are more marked. If the rigidity remain persistent it indicates acute general peritonitis. The tenderness, he observed, is best marked at McBurney's spot, and the reason that this is the point of greatest pain is that it is just at this part that the appendix arises from the cæcum. Though we may have appendicitis without the sign of any tumour, a swelling is generally present on the second or third day in the right iliac fossa; with a long appendix hanging in the pelvis the tumour cannot be felt. The tumour may consist of intestine, peritoneum, exudation, and possibly pus, and therefore dulness is not persistent. Should, however, a tympanitic note remain persistent, the signification is that there is gas in an abscess cavity. The formation of pus, without its evacuation, causes the patient to rapidly waste, and the presence of indican in the urine is noticed. In acute appendicitis, with the formation of pus we have an excessive number of leucocytes in the blood, and this has been relied upon by some as one means for the differential diagnosis of appendicitis from typhoid.

The Treatment of Asthma by Compressed Air Baths.

THIS peculiar form of treatment can be seen in progress at Ben Rydding and at the Brompton Hospital for Consumption, in connection with which Dr. Wethered recently described the method in the course of a clinical lecture. The curative agency is a system of compressed air baths. The "air bath" holds five or six people, and resembles a huge diving bell. The bath is continued for a couple of hours. The first half-hour is occupied in increasing the pressure of the air from one

to nine atmospheres, at which it remains for an hour, and then it is gradually lowered to the normal. It has been found that if the alterations of pressure are made with any suddenness the patients experience much discomfort. When the pressure is first put on the patients feel an uncomfortable sensation, chiefly in the ears and throat, but they can get rid of this by swallowing some liquid. The relief afforded seems permanent. The air is compressed by steam power. A whistle is provided by which, if any patient feels unwell, communication can be established with the attendant, who looks in at one of the windows provided. The attendant is always close at hand while the bath is being taken and periodically looks through the window. In case of any accident occurring to one of the patients the pressure is of course lowered comparatively suddenly.

Birmingham University.

THE spectacle of the uprising of strong and vigorous young Universities in the provinces has been made familiar by repetition. The success of these seats of learning has long since been assured, to the no little consternation of the olden academic institutions. Birmingham has now followed suit by appointing Mr. Joseph Chamberlain as the Lord Chancellor. The selection of a shrewd business man and politician to such a post will come as a revelation to those who are accustomed to regard scholarship as a *sine qua non* of fitness for the distinguished position in question, the first meeting of the Court of Governors of the University it was announced that £330,000 had been already received, but that another quarter of a million was needed to place the University on a proper footing. It may well happen that Birmingham will show the community how university life can be made to blend scholarly ideals with the needs, wishes, and aspirations of practical everyday life. When will London learn the lesson, and provide a popular university or universities on teaching lines, that have made the younger provincial institutions of the kind in the highest degree attractive to the utilitarian youth of the present generation? One may hope that Birmingham will solve the problem of imparting a sound education without the necessity of testing results by high-standard examinations. That difficulty will have to be faced by future educational reformers.

The Friendly Societies in Sunderland.

THE medical officers of the friendly societies in Sunderland have recently sent a notice to the various lodges that commencing with June their charge would be four shillings yearly for each member, instead of three shillings as heretofore. As might be expected this demand has been met with great opposition on the part of the society members. Reducing the situation to plain figures each member secures the right to medical attendance and medicine during sickness by a payment of threepence per month, which the medical officers say must be

increased to fourpence. Either rate of remuneration is scandalously inadequate, and medical men have themselves to thank for the degrading position in which they are placed in the matter. As a natural consequence of their demanding the extra penny a month the societies contemplate forming a medical aid association whereby they can engage the whole services of qualified practitioners and make a handsome profit out of the transaction. Past experience has shown that there will be no lack of black sheep among the profession willing to accept such posts. It is painful to see the straits to which an honourable profession has been reduced by its lack of organisation, as shown by the highly qualified men who are actually at the present moment salaried servants of the friendly societies. It is a thousand pities that the General Medical Council has confined its action to abstract resolutions upon a matter of vital interest to the dignity and prosperity of the medical profession.

How Scarlet Fever is Spread.

THE local authorities of St. Helens have recently prosecuted a woman for exposing her child while suffering from scarlet fever. It appears that the case was duly notified in the first place to the Medical Officer of Health, whose inspector subsequently visited the house on April 18th, and in vain endeavoured to persuade defendant to send her child to the fever sanatorium. On May 7th the latter officer again visited the house, and discovered the child downstairs along with other children. On May 14th he saw the child playing in the street. Next day the Medical Officer of Health examined the child, whom he found in an infectious condition, with the skin peeling from the hands and feet. The defendant was fined one pound and costs for the exposures on the 14th and 15th May. In this case the authorities appear to have exercised due patience and forbearance before taking any extreme step, and it is to be hoped that the result of the prosecution will act as a warning, far and wide, against such criminal recklessness. Fortunately, the popular verdict nowadays is all in favour of the infectious hospitals, where the accommodation is often overtaxed. By the way, the mention in the foregoing case of the desquamating hands and feet as a sign of infectiveness reminds one of a trial in the Midlands some years ago, when a number of sanitary experts gave it as their deliberate opinion that the infection of scarlet fever was independent of the desquamation. It is a pity the point has not been definitely settled.

A New Medical Society.

It is somewhat curious that among the many medical societies that flourish in London at the present moment not one is devoted to so important a subject as that of the diseases of children. In no single branch of medicine has specialisation been more necessary and been attended with more brilliant results. It is therefore with much pleasure we hear that a preliminary meeting is to be held on Monday

June 11th, 5.30 p.m., at 20, Hanover Square, London, for the purpose of discussing and it is to be hoped also of inaugurating this most desirable departure. A preliminary circular calling the meeting has so far been issued to the members of the staffs of the various children's hospitals, provincial and metropolitan, and of the officers of the Schools' Association. From the wording of the circular it seems clear that the promoters of the scheme will welcome at the preliminary meeting any members of the medical profession who are likely to help in the movement. The proposal has our hearty support and approval, and we shall watch future developments with a good deal of interest. Nowadays the necessity of a society for the mutual interchange of special observations must be acknowledged by every candid man. We may venture to express a hope that the work of such a body, if founded, will be largely on clinical lines.

An Untruthful Vaccination Certificate.

THE efficacy of any legislation for affording protection against small-pox must necessarily depend upon the trustworthiness of the medical men who undertake to perform the operation, and although there have been rumours that a certain number of practitioners of anti-vaccination proclivities do not fulfil their duties in this respect, we prefer to believe that such conduct is quite exceptional. Any shortcomings in this respect merit condign punishment not only at the hands of the authorities, but also at the hands of the General Medical Council. We regret to find that Mr. Walter Towell Colman, described as a medical practitioner of Rowbarton, but whose name we are unable to find in the *Medical Register* for 1900, has been fined for delivering a certificate of successful vaccination in respect of a child who, in point of fact, had not been vaccinated, or, if vaccinated, without result. The only excuse was that the defendant had been prevented by illness from ascertaining for himself that the operation had had the desired result. The magistrates rightly described the offence as a very serious one, and if the attention of the General Medical Council were called to the case we have little doubt that Mr. Colman's conduct would elicit equally grave condemnation, possibly with more serious consequences than a mere fine.

Blind Medical Rubbers.

ANYTHING that offers a fresh occupation to the blind deserves careful consideration by the philanthropic. The proposal that blind people may be taught to become medical rubbers is worthy of attention. There can be no doubt that the deprivation of sight is almost always to some extent compensated by a greater delicacy of touch. The blind medical rubbers in Japan are famous handicraftsmen who form familiar figures in the streets of the great towns of that Empire. It is said there are some twenty persons who follow the calling under similar circumstances in Moscow and many more in St. Petersburg. Unfortunately during late years medical rubbing has

gone out of fashion, a result not remotely connected with the abuses that have sprung up around the practice of massage. Indeed, speaking generally, the process of rubbing seems likely to be superseded at no distant date by the superheated air treatment. At the same time there would doubtless be a limited opening for one or two skilful and well-trained blind rubbers. It is a mistake to suppose that proficiency in massage comes as an inspiration; on the contrary, it can be attained only by careful study and practice.

Sailors and Lung Diseases.

It might almost be said of the lung diseases of sailors as it was of the classical snakes in Iceland, namely, they do not exist. While such an assertion would not be literally true, yet it is not a little remarkable the almost complete immunity enjoyed by sailors in that particular direction. It is clear, therefore, that constant exposure to extremes of wind and weather does not induce disease of the respiratory organs. That fact has long been recognised by medical men, but the real significance of the observation is hardly yet grasped in its full therapeutical bearing. The open air treatment of phthisis is the logical outcome of the comparative immunity from that complaint conferred by a life at sea. It seems more than likely, indeed, that the curative effects of a long sea voyage for phthisical patients is not yet estimated at its proper value. In former days sufferers were too often sent away in the last stages of the malady to face the discomforts of life on board a sailing ship. Notwithstanding the improvements effected in the cabin construction of British ships by the regulations of the Board of Trade, there is still room in many instances for better systems of ventilation. The quarters of the crew are often overcrowded to such an extent that it is a wonder how the men preserve their health, especially in hot climates. More than half the deaths that occur in the British mercantile service are from drowning. It would be interesting to note the effect upon the death roll of introducing the principle of employers' liability into nautical life.

An Implied Contract.

No legal obligation rests upon a medical practitioner to attend when summoned to a sick or injured person, but the moment he promises to see the patient any failure so to do may be construed to be a breach of contract, thus creating a liability to damages. This, at any rate, is the law as laid down by Judge Gwynne James, of the Warrington County Court, in a case which came before him last week. Briefly stated, the facts were as follows:—An old patient of Dr. Parker, of Stockton Heath, sent for him early one morning to attend to an injury to the leg received on the previous day. Dr. Parker, apparently, took offence at the messenger's manner and did not go, although he seems to have given some sort of promise to do so, nor did he respond to two subsequent calls. When he sent in his bill for services previously rendered, he was met by a claim for damages on the ground of negligence.

and the Judge admitted the claim as well founded, and even refused leave to appeal. Judge James' decision does not, of course, establish the legal position beyond question; it is merely his personal opinion, and we doubt greatly whether the proposition would be endorsed by a higher court. On the other hand, we have scant sympathy for a practitioner who allows his temper to influence him in fulfilling professional obligations. He certainly contracted a moral, if not a strictly legal, liability; and if we question the legality of the Judge's ruling we do not hesitate to affirm that it is substantially just.

Medical Men and Duelling.

MEDICAL practice in Germany is, under certain conditions, complicated by the necessity of observing what are euphemistically termed "the rules of honour." This translated into plain English means that a medical man connected with the German military organisation is to deliberately attempt the murder of one of his fellows if unfortunate enough to be submitted to a gross insult with the added contingency that because he has been subjected to rudeness he must also run the risk of losing his own life. The penalty for refusing to comply with such a barbaric code of morals is an ignominious dismissal from the official post held, and it will come as a surprise to many that such an occurrence has happened so recently as within the last few weeks. The medical officer who has thus suffered for daring to have his own opinion on the wickedness of consenting to be an accessory to murder is reported to be the director of a medical institution at Tilberg. There seems but little reason to doubt the accuracy of the intelligence, and it is to be sincerely hoped that in this case the misfortune of the individual may stir up a wholesome revulsion of feeling against the glaring iniquities inseparable from the practice of duelling.

Foreign Graduates and Qualification.

IN the absence of an understanding as to reciprocity of practice with foreign countries, it would seem only reasonable that graduates of foreign universities should be admitted to qualifying examinations in this country on their showing that they have gone through a course of medical study not inferior to our own. Far from this being the case, the foreign graduate, as such, has, we believe, no status at all, and in the event of his desiring to qualify in this country he is compelled to go through the whole course *de novo*. This protection in its narrowest and worst form, and is unanimously declared to be in the last degree objectionable when applied to ourselves, as is now the case in France. The ability to pass the final examinations in the English language is surely evidence enough of a sufficient standard of professional acquirements, and except in the interests of those who derive pecuniary benefit from teaching, we fail to perceive any valid reason for imposing vexatious additional requirements.

The London Colleges and the Medical Council.

THE Royal Colleges in London maintain their impenitent attitude of non-compliance with the requirements of the General Medical Council in respect of the scientific education of medical students. The Council, it will be remembered, claim the right to restrict recognition to institutions approved by it for the purpose, a claim for which the Colleges declare themselves unable to find any statutory authority. One way out of the deadlock would obviously be for the Council to refuse admission to the *Students' Register* to persons who have not received their scientific training in accordance with the Council's regulations, but as it would manifestly be unfair to make a whipping stock of the unhappy student the question of legality of the Council's pretensions has been referred to the legal advisers, a course which one might have expected would have been taken earlier in the day. Whatever the legal position may be, our sympathies are with the Council, and we trust it will be able to vindicate its attitude.

The Apothecary as Physician and Surgeon.

It will be noted that the Medical Council does not propose to fall in with the suggestion to go halves with the Society of Apothecaries in the cost of promoting a dummy lawsuit for the purpose of testing the right of the Society's licentiates to style themselves physicians and surgeons, and it must be admitted that the Council's position is perfectly logical. If the Society regard these titles as potential assets, it is for them to establish the right of their licentiates thereto, a right which, as matters stand, is denied them on the strength of judicial decisions. In view of the comparatively small number of persons who practise solely on the strength of this diploma, the question is hardly worth fighting over, and the profession would assuredly be entitled to object to large sums of money being wasted in any such manner.

The Epidemic of Small-Pox at Montreal.

THE sanitary authorities of Montreal learned wisdom by the bitter experience of a heavy death-rate in 1885 occasioned through an epidemic of small-pox. They have turned their hardly earned knowledge, gained at so heavy a cost, to useful account, for they have not hesitated to provide the amplest funds for the necessary measures to be carried out to ensure that their city shall be freed as soon as possible from the present epidemic of small-pox, fortunately of a mild type. It would be well if such an excellent condition of municipal readiness and resource were to be found in all towns, it would undoubtedly mean the saving of many an innocent victim.

As evidence of the progress of cremation, it may be recorded that the Leicester Corporation has been empowered to borrow £3,000 in order to erect a crematorium in its new cemetery at Gilroos.

CHOLERA is said to be ravaging Rajputana in Bombay to such a fearful extent that 5 per cent. of

its population have succumbed to it during the last month.

THE annual election to the Council of the Royal College of Surgeons of England is to take place on Thursday, July 5th, at 1.30 p.m.

PERSONAL.

PROFESSOR PORRO, whose health has recently given cause for some apprehension, has now completely recovered.

DR. THOMAS MYLES has been elected President, and Dr. Lambert H. Ormsby, Vice-President of the Royal College of Surgeons, Ireland.

DR. ROBERT J. COLLIE has been appointed medical superintendent of the Ambulance and Home Nursing Classes of the London School Board.

THE Earl of Pembroke and Montgomery will distribute the prizes to the successful students at Guy's Hospital Medical School on July 4th.

MR. A. PEARCE GOULD, Surgeon to the Middlesex Hospital, has come forward as a candidate for election to the Council of the Royal College of Surgeons of England.

MR. H. T. BUTLIN is announced to deliver the Cavendish Lecture before the West London Medico-Chirurgical Society at the Hammersmith Town Hall, on Friday, June 22nd, at 8.30 p.m.

A SYMPATHETIC feeling will be excited throughout the profession for Mr. Frederick Treves, whose daughter died suddenly on Thursday last at the age of 18. Mr. Treves has but recently returned from the Transvaal.

DR. F. DE HAVILLAND HALL has been re-elected chairman of the Medical Sickness Annuity and Life Assurance Society, a post which he has filled without interruption since the resignation of the late Mr. Ernest Hart.

THE MEETING AT THE ROYAL COLLEGE OF SURGEONS, IRELAND.

ON Saturday last, the 2nd inst., the Fellows of the College held their annual general meeting to receive from the Council its report and financial statement. The chair was occupied by Mr. Swan, the outgoing President, and the attendance of Fellows was less than might have been expected considering the importance of the business to be transacted.

The report having been presented, a resolution was submitted congratulating the Council on the freedom of the College from debt and upon other evidences of prosperity.

Dr. Jacob then moved a resolution recommending the Council to take steps to prevent the future issue of any diploma, under any circumstances, without the knowledge and approval of the Council. He explained that he was obliged to take this course because of the recent admission to the examinations for the Conjoint Public Health Diploma of a Mr. MacWalter, whose name and credentials had not been previously submitted to the Council, although there were circumstances which made it very doubtful that the Council would approve if it had been asked. After some debate, Dr. Jacob's resolution was adopted, on a show of hands, by 14 votes to 1.

The College then proceeded to consider resolutions deprecating the practice of canvassing by candidates for office in the College, which were moved by Surgeon-General Kilkelly and Mr. Fitzgibbon. An amendment was moved by Mr. Swanzy, which remitted the question to Council, with a suggestion that, in future, the Council of the day should consider the relative claims of candidates, and should advise the Fellows as to whom they should support. The amendment was adopted, and subsequently Mr. Fitzgibbon's resolution in favour of a specific warning being printed on the voting paper was adopted by a majority of one.

On Monday the ballot for the election of President, Vice-President, Secretary of the College and Councillors was proceeded with. Mr. Swan again occupied the Presidential Chair until the unopposed election of Mr. Myles to the Presidency was declared, when the latter gentleman assumed the chair, and a vote of thanks to the outgoing President was unanimously adopted.

Sir Charles Cameron was unanimously elected Secretary of the College. The chief contest was for the Vice-Chair between Mr. Ormsby of the Meath Hospital and Mr. Heuston of the Adelaide. 252 voting papers were received, and, in the event, Mr. Ormsby won the seat by 140 votes, against 103 for Mr. Heuston—majority 37 votes.

For the 19 Council seats there were 24 candidates—whose names we printed last week—including 16 of the outgoing councillors. In the result the following were elected:—Archibald H. Jacob, 19; Edward Hallaran Bennett, 18; Sir Philip Crampton Smyly, 16; Robert Lafayette Swan, 20; Sir William Stokes, 11; Henry Rosborough Swanzy, 15; Sir William Thomson, 8; Austin Meldon, 18; Sir Charles A. Cameron, 15; Richard D. Purefoy, 14; John J. Cranny, 19; Henry Gregg Sherlock, 21; Charles B. Ball, —; John B. Story, 13; John Lentaigne, 16; G. Stoker, —; Arthur Chance (elected, January 8th, 1900), 8; Richard Bolton McCausland, 21; Frederick Conway Dwyer, —.

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

AN UNUSUAL OBSTETRIC CASE.

SIR,—A short time ago I was called to attend a multipara, and on my arrival I found the following conditions:—The pelvis was larger than the normal, the os uteri was rigid, and its anterior lip greatly swollen and oedematous. I learnt that the liquor amni had escaped some time before I was sent for. As the woman had been a considerable time in labour, I decided to dilate the os uteri and apply the long forceps, which I did. On making traction the womb came down into the vaginal space, and the forceps slipped. I re-applied them, and when doing so was pleased to find that the oedema of the anterior lip had almost disappeared. The child was safely delivered, and the woman has made a good recovery:

I am, Sir, yours truly,
J. S. SWANN.

[The older writers drew attention to the risks to both mother and child where the pelvis was larger than normal. They enumerate the troubles as follows:—(a) A descent of the uterus; (b) retroversion of the uterus; (c) a too rapid expulsion of the child. Edema of the anterior lip is usually caused by pressure of the vertex not occurring in direction of the os uteri, but on the anterior wall of the cervix. When seen in time the faulty position is easily remedied by slipping the finger of the practitioner into the os uteri and during an

interval of the pain drawing the lip into position and retaining it there until the completion of the next pain. The dilatation of the os uteri, and the application of the forceps by correcting the presentation allowed the veins of the circle of Hewit to empty themselves and the œdema disappeared.—ED.]

THE COMPOSITION OF THE CENTRAL MIDWIVES BOARD.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Immediately after the motion expressing approval of the interim report from the Midwives Bill Committee of the Medical Council had been passed, Mr. George Brown raised an important question by suggesting that the proposed Central Midwives Board should contain five regular medical practitioners. In view of the fact that the Midwives Bill now before the House does not contain any provision providing that a midwife shall call in a medical man in cases of abnormality, the necessity for a proper representation on the board of medical interests is of great urgency. Dr. MacAlister's contention that the Council had already approved of the constitution of the board was really not applicable because the circumstances had changed in consequence of the provision above stated having been omitted from the Bill.

I am, Sir, yours truly,

OBSERVER.

ELECTION OF FELLOWS AT THE ROYAL COLLEGE OF PHYSICIANS, LONDON.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your issue of May 9 contains a paragraph dealing with the election of Fellows of the Royal College of Physicians of London. It is imputed therein that these honours are distributed in an unfair way, and the general tone of your remarks conveys the impression that the College shares the politics of Tammany Hall or any other corrupt public body.

Now, Sir, anyone who knows the facts of the case must be aware that the Fellowship is bestowed, *honoris causa*, without fear and without favour, solely upon those who have shown themselves worthy of the distinction by their academic, social and scientific achievements. That a medical journal should indulge in such unworthy insinuations is to me simply appalling.

In conclusion, I hereby challenge you, Sir, to produce a single instance where the Fellowship of the Royal College of Physicians of London has been either unduly withheld or improperly bestowed.

I am, Sir, yours truly,

AN INDIGNANT FELLOW.

Brook Street, Grosvenor Square,
London, W., May 28th, 1900.

[We insert our correspondent's communication, but we do not propose to take up the challenge he has thrown down. It is not for us to bell the unworthy cat.]

CAMBRIDGE APPOINTMENTS ASSOCIATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The words "as assistants, &c." were added to my letter, I think you will find, by some kindly hand in your office. I am glad that their insertion gives me the opportunity of saying how delighted we shall be to give "Inquirer," or any other of your readers, the fullest information as to this Association if he or they will send us a post-card.

As to the general question of the utility of a Cambridge career as a medical training we can only point to the very flourishing state of the medical school here, and we can assure "Inquirer" that the needs of the coming general practitioner are quite as carefully looked to as those of the specialist. The June number of the *Appointments Gazette* contains an article by Professor Clifford Allbutt, which we feel sure will be of interest to "Inquirer," and we shall be glad to send him a copy.

I am, Sir, yours truly,

W. A. J. ARCHBOLD.

73, Trumpington Street, Cambridge, June 2, 1900.

Obituary.

MR. JAMES GROSVENOR MACKINLAY, F.R.C.S.

THE death is announced of Mr. James Grosvenor Mackinlay, F.R.C.S., Edinburgh, senior ophthalmic surgeon to the Royal Free Hospital, at his residence in Stratford Place, W. He was the eldest son of the late Dr. John Mackinlay, a surgeon in the Hon. East India Company's service from 1824 to the expiration of the Company's commercial charter in 1854, and afterwards in practice for 30 years at Isleworth. Mr. Mackinlay was educated at Charing Cross Hospital, and in 1865 became a Licentiate of the Royal College of Physicians and a member of the Royal College of Surgeons. He afterwards devoted himself to the study of the diseases of the eye, and was at one time or another medical registrar, house surgeon, clinical assistant, and surgeon to the Royal Westminster Ophthalmic Hospital, surgeon to the Royal Eye Hospital, and surgeon to the Western Ophthalmic Hospital.

DR. FRANK MATHEWS, OF CAVAN.

THE much-regretted death of this gentleman took place in the last week in April. He obtained the L.E.C.P. and L.R.C.S.I. in 1894, having carried off medals in materia medica and therapeutics in the school of the College of Surgeons. He afterwards served as medical officer of the Stradone Dispensary, and died at a regrettably early age.

SURGEON-CAPTAIN H. E. DOWSE.

WE regret to announce the death, from enteric fever, of another member of the Royal Army Medical Corps, Captain Henry E. Dowse, at Bloemfontein, *et. 32*. Deceased was educated at the Westminster Hospital and qualified in 1889. He joined the Army Medical Staff as Surgeon-Captain in 1891, and served with the Chitral Relief Force in 1895, for which he received the Frontier medal with clasp.

DR. H. G. DYER.

WE regret to announce the death of Dr. H. G. Dyer, Medical Officer of the Ringwood Union and Rural District. Death resulted from an abdominal operation at the comparatively premature age of 51. Deceased qualified as L.E.C.P.Ed., 1873; M.R.C.S. of England, 1873; and M.D. Durham, 1890.

Medical News.

Medical Graduates' College and Polyclinic.

LORD STRATHCONA presided on Thursday evening last at the annual dinner of the Medical Graduates' College and Polyclinic, which was held at the Trocadero Restaurant, and was supported by a large number of members and distinguished guests. The loyal and patriotic toasts having been honoured, the chairman, in proposing the toast of the evening, said they were told that of all forms of charity that which preserved the health of the community was the most efficient and economical. The Medical Graduates' College and Polyclinic presented itself as the means of assisting in the best possible way in the preservation of health. It did not demand great hospital buildings of its own or conflict with ordinary hospital work, but gave patients the means of having the best advice while they remained in their own homes. It also provided for the sending of those who would be better cared for in hospitals to some one of the principal hospitals in London. It aimed at bringing together for further instruction those who had graduated in medicine or surgery, so that they might keep abreast of the advance of the science of their profession. It brought within its doors practitioners, not only from all parts of the United Kingdom, but from abroad and from the different outlying parts of the Empire. Speaking of the colonial members of the medical profession, he expressed

the hope that we should some day have one order of the profession extending to all parts of the Empire. Sir William Broadbent, the president of the institution, replied. He said it was his appreciation of Mr. Hutchinson's high motives and great enthusiasm that led him to associate himself with the scheme. The institution endeavoured to afford an opportunity for qualified medical men to apply themselves to the acquisition of new knowledge and to complete their education by attending classes in all the different special subjects which could not be completely studied during their hospital career. One of their greatest sources of encouragement was the fact that an increasing desire was shown by medical men to add constantly to those departments of knowledge which made them more efficient for their life's work. Mr. Hutchinson proposed "The Hospitals and Kindred Institutions," remarking that there was no sort of competition between the Medical Graduates' College and Polyclinic and the general hospitals. They had never intended to have a large hospital, but they had not succeeded quite to their heart's content in establishing a direct connection between themselves and other institutions, but this was only a matter of time. They were anxious to be co-workers with kindred institutions, and to send those who were associated with the Medical Graduates' College into the wards of all the great hospitals. Mr. Sydney Holland replied. Sir J. Fyner proposed the toast of "The Guests," Mr. Brudenell Carter responding.

The Centenary of the Royal College of Surgeons of England.

THE arrangements are being completed at the Royal College of Surgeons of England for celebrating its centenary at the end of July. On July 26, Sir William MacCormac, the President, will deliver an address in the theatre of Burlington House. In the evening a festival dinner is to be held in the great hall of Lincoln's Inn. On the following evening the Lord Mayor gives a reception at the Mansion House.

Clinical Laboratories at Westminster.

THE opening of the new Clinical Laboratories of the Westminster Hospital is announced to take place on Tuesday, June 12th. The ceremony will be formally conducted by Lord Lister, F.R.S., and a number of distinguished guests have been invited. The laboratories are fitted up for research by the chemical, bacteriological and other methods of diagnosis demanded by advanced modern clinical work. They have been fully, and indeed elaborately, equipped at great expense, and the result is one of the finest clinical laboratories not only in the United Kingdom, but perhaps in Europe. This energetic step cannot fail to enhance the value of the teaching at Westminster, and thereby attract students to the School.

Donations to Hospitals.

The trustees of Smith's (Kensington estate) Charity have contributed £500 to the general funds of St. Thomas's Hospital; £300 to the Dental Hospital of London, Leicester Square, W.C.; and £300 to St. Mary's Hospital, Paddington.

THE Medical, Surgical, and Hygienic Exhibition at the Queen's Hall, Langham Place, which has now become an annual event, opened its doors on Tuesday, June 5th, and will remain on view until the 8th inst. There is a copious programme of instrumental music, which will help to beguile the afternoons and evenings, Art being thus constituted the handmaid of Commerce. The popularity of this exhibition during past years shows that it fulfils a want.

A DEATH from chloroform was the subject of an inquest at Ashford (Kent) last week, the victim being a man, æt. 39, who was about to be operated upon for cancer of the tongue. No information is vouchsafed as to the quantity of the anæsthetic administered nor as to the method adopted.

A MEETING to consider the desirability of forming a society for the advancement of the study of children's

diseases is to be held at 20, Hanover Square, on Monday, June 11th, at 5.30 p.m.

At the Bankruptcy Court on Friday last an application for discharge was made by Mr. F. F. G. Granville, a surgeon, described as of South Kensington, who stated that his insolvency was due to expenses incurred by him on behalf of his mother-in-law, and to loss of practice caused by her presence in his house. The receiving order was made in October, 1887. Mr. R. V. Williams, on behalf of the bankrupt, pleaded that his failure was due to misfortune, "his mother-in-law being a semi-lunatic." His immediate discharge was granted.

University of London—Rogers Prize.

At a meeting of the Senate of the University of London, held on March 28th, 1900, it was resolved that one sum of £100 be offered as the Rogers Prize open for competition to all the members of the medical profession in Great Britain and Ireland, for an essay under the following regulation as to the subject and conditions thereof, namely:—An essay by any member of the medical profession in Great Britain and Ireland upon the "Production of Immunity in Specific Infective Diseases"; generally, and with particular reference to any one disease on which the writer of the essay has made original investigations. The essay is to be sent to the Registrar, University of London, South Kensington, S.W., on or before June 1st, 1901.

St. Thomas's Hospital House Appointments.

The following gentlemen have been selected as House Officers from yesterday (Tuesday), June 5th:—

House Physicians: H. R. Beale, L.R.C.P., M.R.C.S. (Extension); L. S. Dudgeon, L.R.C.P., M.R.C.S. (Extension); E. W. Hedley, M.A., M.B., B.C., Cantab.; F. C. Eve, B.A., M.B., B.C., Cantab.

Assistant House Physicians: H. M. Harwood, M.A., M.B., B.C., Cantab.; R. B. Kinloch, L.R.C.P., M.R.C.S.

House Surgeons: A. Webb Jones, L.R.C.P., M.R.C.S.; E. A. Gates, L.R.C.P., M.R.C.S.; E. C. Bourdas, L.R.C.P., M.R.C.S.; N. Unsworth, L.R.C.P., M.R.C.S. (Extension).

Assistant House Surgeons: A. E. Martin, M.A., M.B., B.C., Cantab., L.R.C.P., M.R.C.S.; C. L. Hawkins, M.A., M.B., B.C., Cantab., L.R.C.P., M.R.C.S.; J. F. Cunningham, L.R.C.P., M.R.C.S.; Y. Takaki, L.R.C.P., M.R.C.S. (Extension).

Obstetric House Physicians: (Senior) A. Bevan, L.R.C.P., M.R.C.S.; (Junior) B. F. Howlett, L.R.C.P.; M.R.C.S.

Clinical Assistants in the Throat Department: A. J. B. Adams, L.R.C.P., M.R.C.S.; C. F. Selous, L.R.C.P., M.R.C.S.

Clinical Assistants in the Skin Department: G. Black, L.R.C.P., M.R.C.S.; C. A. R. Nitch, L.R.C.P., M.R.C.S.

PASS LISTS.

University of London.

The following is the official list of successful candidates at the May examinations:—

M.B. PASS EXAMINATION.

FIRST DIVISION.

Herbert Cecil Barlow, John Thomas Dunston, Alfred Gordon Ede, Arthur Tregelles Fildham.

SECOND DIVISION.

Cornelia Bonte Sheldon, Thomas Anstey-Chave, Alfred John Vernon Betts, Isobel Sarah Bryson, Lewis Cook, David Leighton Davies, Alexander Fraser, Cecil Scarlett Frost, George Robert Harcourt, Francis Joseph Hasselacher, Ernest William Holyoak, John William Hunt, William Sam Inman, David Thomas Cadvan Jones, Charles Voughton Knight, Charles James Izzard Krumbholz, William Henville Lowman, Maurice Taylor Male, Ernest Alfred Miller, B.Sc., Frank Mayo Morris, Richard Bothwell Mow'l, Harold Rothery Nutt, George Chetwode Owsley, William Panckridge Panckridge, Thomas Perrin, George Edward James Antoine, Henry Harold Scott, Nigel Frampton Stallard, William Stuart Vernon Stock, Rhys Tudor Thomas, Robert Lewis Thornley, Sydney Gordon Tippet, Frank Douglas Turner, Lewis Augustus Walker.

Notices to Correspondents, Short Letters, &c.

✉ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

LAYMAN.—Yes, it is a fact that the night air of towns is purer than that of the day. For all that, the majority of citizens shut themselves up every night in a practically air-tight chamber, which they proceed to poison with their own emanations. The principles of ventilation should be taught in every school, as a matter of vital importance to the proper preservation of health. As a matter of fact, nine out of ten school teachers are themselves ignorant of the subject, and fail in the ventilation of the schoolroom. We should advise you to bring pressure upon candidates at the next School Board election in your district.

MACBETH UP TO DATE.

A CORRESPONDENT sends us the following, with modified metre:—

Thyroid of a black-faced sheep
In the cauldron boil and steep
Brain of pig and spine of dog,
Testes of lascivious hog.
Double, double, toil and trouble,
Fire burn and cauldron bubble.
Medulla of a rabid bitch,
Lain a fortnight in a ditch;
Bacillus of an anthrax rat,
Cocci grown in putrid fat;
Add a pint of clotted blood,
Make the spell both strong and good.
Double, double, toil and trouble,
Fire burn and cauldron bubble.

CLINICIAN (Devonport).—The presence of a few epithelial cells in the urine is not of any diagnostic importance. It is probably due to a catarrh of some part of the urinary tract, the precise seat of the trouble being indicated in some cases by the shape of the cells. Cancer cannot, as a rule, be exactly differentiated from the other cells with certainty. The diagnosis in that disease may be determined by other local signs and symptoms, together with the age of the patient and general cachexia. Spermatozoa may occur in healthy urine.

W. A. S.—To search for gallstones the faeces should be mixed with water and thoroly broken up with a piece of wood. The whole mass can then be strained through muslin. Obstruction of the bowels is sometimes due to concretions formed round a gallstone as a nucleus. Hence a history of biliary calculus is of some importance in intestinal obstruction.

Meetings of the Societies and Lectures.

WEDNESDAY, JUNE 6TH.

OBSTETRICAL SOCIETY OF LONDON.—8 p.m. Specimens will be shown. Paper:—Mr. A. Doran (President): A Case of Extra-uterine Gestation in which Fetal Death occurred at the Eighth Month after Spurious Labour, Abdominal Section two months later.

THURSDAY, JUNE 7TH.

THE RONTGEN SOCIETY (St. Bartholomew's Hospital).—8 p.m. Dr. Lewis Jones will show an Influence Machine, of American design. Mr. James Wimshurst, F.R.S., will give a short statement of his work in the design and the perfecting of the several forms of his Influence Machine. Dr. Remy, of Paris, will show a new Localising Apparatus.

MONDAY, JUNE 11TH.

ODONTOLOGICAL SOCIETY OF GREAT BRITAIN (40, Leicester Square).—8 p.m. The President will move:—"That Bye-law 70 be suspended during the Session 1900-1901." (Bye-law 70.—The ordinary meetings of the society shall be held on the first Monday in each month, from November to June, both inclusive, at 8 p.m. precisely, except in the month of January, or when an Act of Parliament holiday occurs on that day, the meeting shall be held on the Monday next ensuing.) Communications by Mr. Frederick Eve, Mr. W. R. Beeve, and Mr. W. R. Humby.

Appointments.

BEGGS, J. E., M.D.Camb, D.P.H., Medical Officer for the Grove Hospital, Metropolitan Asylum District.
BENNETT, W. F. COCKAYNE, L.B.C.P., L.R.C.S. Edin., L.S.A. Lond., House Surgeon to the Staffordshire General Infirmary.
EVANS, T. J., L.R.C.P. Lond., M.R.C.S., Medical Officer for the Third Sanitary District of the Llandoverly Union.
FORSTER, FREDERICK C., M.R.C.S. Eng., L.B.C.P. Lond., Resident Medical Officer to the Royal United Hospital, Bath.
FORSTER, R., L.S.A., House Physician to the General Infirmary at Leeds.
LUCKHOFF, J., M.B. Edin., House Physician to the General Infirmary at Leeds.
MAIDLAW, W. H., M.D., B.S., F.R.C.S., Medical Officer of Health for the Ilminster (Somerset) Urban District.
MESSITER, A. F., L.R.C.P. Lond., M.R.C.S., Medical Officer for the Epworth Sanitary District of the Thorne Union.
MITCHELL, A. M., M.D. Camb, D.P.H., Medical Officer of Health for the Borough of Guildford.
MORRISON, W. H. M.B., Ch.B. Vict., House Surgeon to the General Infirmary at Leeds.

MORTON, S. ERNEST, M.R.C.S., L.R.C.P., Assistant Honorary Medical Officer to the Children's Hospital, Sheffield.
PUSLOW, C. E., M.D., M.R.C.P. Lond., Ingleby Examiner in the University of Birmingham.
SHEEN, A. W., M.D. Lond., F.R.C.S. Eng., Honorary Surgeon to the Cardiff Infirmary.
STEWART, A. H., M.B., C.M. Glasg., Medical Officer for the Eighth Sanitary District of the North Brierley Union.
TELLING, W. MAXWELL, M.B., B.S. Lond., Resident Medical Officer to the General Infirmary at Leeds.

Vacancies.

Birkenhead and Wirral Children's Hospital, Woodchurch Road, Birkenhead.—House Surgeon for twelve months. Salary £100 per annum, with board, residence, and laundry.
Barnby Union.—Newtownsgore Dispensary Districts.—Medical Officer for above Dispensary Districts. Salary £90 a year, together with vaccination fees, &c. Applications, accompanied by diplomas and certificates, to James McGovern, Clerk of the Union. (See advt.)
Bristol Royal Hospital for Sick Children and Women.—House Surgeon. Salary £130 per annum, with rooms and attendance (not board).
Carlisle Dispensary.—Resident Surgeon, unmarried. Salary £150 per annum, with apartments (not board). Also House Surgeon. Salary £130 per annum, with apartments, (not board). Apply to the Hon. Sec., 23, Lowther Street, Carlisle.
Carmarthen Union.—Medical Officer and Public Vaccinator, to reside at Conwil, for the Conwil (a Welsh) District, Salary £80, with certain extra medical fees. Applications to the Clerk, 7, Hall Street, Carmarthen.
Corporation of Manchester.—Monsall Fever Hospital.—Third Medical Assistant for one year. Salary £100, with board and lodgings. Applications to the Chairman of the Sanitary Committee, Public Health Office, Town Hall, Manchester.
Craigleith Poorhouse and Hospital, Edinburgh.—Medical Officer, resident. Salary £100 per annum, with board and apartments. Apply to the Clerk, Castle Terrace, Edinburgh.
Devonshire Hospital, Buxton, Derbyshire.—House Surgeon and Assistant House Surgeon for twelve months. Salary of House Surgeon £100 per annum. Assistant House Surgeon £50, with furnished apartments, board, and washing in both cases.
Great Northern Central Hospital, Holloway Road, London.—House Physician and Junior House Physician, both for six months. Salary of House Physician at the rate of £90 per annum, with board, lodging, and washing in the hospital. Salary of Junior House Physician at the rate of £30 per annum, and board, lodging, and washing in the hospital. (See advt.)
Manchester Royal Infirmary and Dispensary.—Additional Honorary Assistant Surgeon. Applications before the 9th inst., to W. L. Saunders, Esq., superintendent, from whom copy of rules can be obtained. (See advt.)
Northampton General Infirmary.—House Surgeon. Salary £125 per annum, with furnished apartments, board, attendance and washing. Also Assistant to the House Surgeon. Board, lodging, and washing provided, and an honorarium of £25 given.
Pontefract General Dispensary and Infirmary.—Resident Medical Officer. Salary £150 per annum, with furnished rooms, fire, lights, and attendance.
Tower Hamlets Dispensary, Stepney, E.—Resident Medical Officer for one year. Salary £130, with furnished rooms, coals, gas, and attendance.
West Derby Union.—Resident Assistant Medical Officer for the Workhouse, Liverpool. Salary £100 per annum, with first-class rations, apartments, &c. Applications to the Union Clerk, Brougham Terrace, Liverpool.
Woolwich Union.—Resident Assistant Medical Officer for the Infirmary at Plumstead. Salary commencing at £100 per annum, with apartments, rations, and washing. Apply to the Clerk to the Board, Union Offices, Woolwich.

Births.

EDKINS.—On May 27th, the wife of J. S. Edkins, M.B. Camb., of Parkhill Road, Hampstead, of a daughter.
FOULDS.—On May 27th, at Ashlea, Droitwich, the wife of Francis H. Foulds, of a daughter.
MALDEN.—On May 27th, at St. Lawrence, Tunbridge Wells, the wife of Walter Malden, M.B. Camb, M.B.C.S., of a daughter.

Marriages.

SWAYNE-LYON.—On June 2nd, at All Saints Church, Upper Norwood, Francis Griffiths Swayne, M.A., M.B., of Upper Norwood, son of B. A. Swayne, J.P., of Bromsgrove, to Etta Ellen, widow of G. K. Lyon, H.M.I.C.S.

Deaths.

GIMSON.—On May 27th, at Witham, Essex, William Gimson Gimson, M.D., in his 62nd year.
GODDE-SMITH.—On May 26th, at Redbourne, Herts, Fredk. Martin Godde-Smith, M.R.C.S., L.R.C.P. Edin., aged 43 years.
LIDIARD.—On May 26th, at Springbank Road, Hither Green, S.E., Sydney Robert Lidiard, M.D., aged 48 years.
MOGGER.—On May 30th, suddenly, on board the s.s. Umvati, F. Slade Mogger, M.B.C.S., L.R.C.P., of Finchley, aged 63. (Cable from Cape Town.)
SHIRTLEIFF.—On May 25th, at Newlands, Ryde, Isle of Wight, Edward Matthew Shirtliff, M.D., aged 63 years.
STAMPER.—On May 22nd, at Pembroke Dock, South Wales, James Fenton Stamper, M.D., J.P., aged 62.
WOODS.—On May 31st, at Gillingham, Dorset, Theophilus Woods, L.R.C.P., L.R.C.S.I., aged 56.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXX.

WEDNESDAY, JUNE 13, 1900.

No. 24.

Original Communications.

THE RONTGEN RAYS IN DISEASES OF THE NOSE, THROAT, AND NEIGH- BOURING ORGANS. (a)

By JOHN MACINTYRE, F.R.S.E., F.R.M.S., M.I.E.E.,

Surgeon for Diseases of the Throat, Nose, and Ear, Glasgow Royal Infirmary; Lecturer on Diseases of the Throat, Anderson's College, Glasgow.

(Concluded from page 571.)

At the last meeting of our Association, when taking part in the discussion upon Mr. Lennox Browne's paper I said I felt convinced that if physicians and surgeons were systematically to examine cases brought before them, either by means of photography or the screen, a great deal of valuable information regarding early diagnosis would be obtained. Everyone knows that the first time a student uses the stethoscope he probably does not make much of it, and when we reflect upon the long time necessary before he becomes familiar with any instrument, we cannot wonder at a difficulty arising in the first interpretation of an X-ray shadow. A great deal of information can be obtained by looking at a single photograph, or at a single shadow upon the screen, but stereoscopic photographs, and, I am pleased to add, stereoscopic vision, will soon render this work much more simple. Everyone is familiar with the ordinary effects of the stereoscope. An ordinary photograph gives you the height and breadth of the field, but the third dimension, viz., depth, reveals the object in a new, pleasing, and very different aspect, and so it is with stereoscopic X-ray photography. I have become accustomed to the use of a single shadow, but the stereoscope as suggested will take a much more prominent place in our work in the future. In demonstrating this I have brought some photographs of the skull, antrum, internal ear (the latter enlarged from the normal subject), and the chest, and anyone who takes the trouble to study them will soon be convinced of how great an improvement this is as compared with a single picture. Many workers have suggested this, and as far back as 1896 Thompson described the practicability of making X-ray stereoscopic pictures, and probably he was not the first. We go back 50 years to the old form of Wheatstone's, which is the great reflecting stereoscope, and it is to his genius that we owe this valuable instrument. In the early history of the X-rays we passed from photography to the screen, and after stereoscopic photography it is but a step to attempt stereoscopic vision. An instrument of this kind was shown at the Royal Society last year by Dr. MacKenzie Davidson, whose work in this department is so well known. When this valuable instrument is popular and becomes more universally employed,

I have no hesitation in stating that the most valuable results will be obtained by all.

However, let us refer for a moment to the conditions which are absolutely necessary to an interpretation of an object seen upon the screen. First of all, the various forms of the so-called cryptoscope have proved unsatisfactory in my hands—I prefer the room in which I am working to be perfectly dark; secondly, we should have sufficiently powerful and efficient apparatus at our command to penetrate the parts to be examined, and means to raise or lower the vacuum as may be required to bring out different conditions of density; thirdly, a barium-platinocyanide screen should be employed; fourthly, the part of the patient's body to be examined should be most carefully adjusted in front of the tube, and if the condition of the patient be sufficiently good, he should be comfortably placed, so that he may undergo a sufficiently prolonged examination. If possible, the part to be examined should be fixed; fifthly, the tube should be selected for the particular kind of work, and the vacuum raised and lowered so that the different densities may be observed as the successive shadows fall upon the screen. By varying the vacuum and noting the results valuable information is gradually obtained. I need hardly point out that both in medicine and surgery different individuals vary in the normal, and hence it is only by experience and long-continued working with different patients in the normal condition that we come eventually to an actual diagnosis. Let me place before you the following cases as examples of those.

I have shown on the screen the first photograph of a foreign body ever obtained, one impacted in œsophagus, and which was referred to in Lord Lister's address at Liverpool. I have had quite a number of such cases sent to me, and in the majority of them, and in all my own cases the foreign body usually rested at the upper part of the œsophagus or lower part of the pharynx. A fact of interest to us when we refer to the second volume of Morell Mackenzie's Diseases of the Throat and Nose, where he refers to different measurements by Seppey, Browne, and his own. Other cases of a similar nature to the one referred to and shown on the screen, will be seen on the different photographs in the room. In all the cases the foreign body was easily seen upon the screen, and it need hardly be added the successful removal was made easy by the accurate diagnosis.

I am showing upon the screen a photograph of a foreign body in the antrum. The patient has been wearing a tube for some time, but there was a history of her having lost the first tube. The discharge had practically ceased when the introduction of a new tube was followed by increase of the amount of pus through the nostril on the same side. The screen at once revealed the presence of the old tube, and for reference a photograph was taken. I have made use of the screen in detecting foreign bodies in the larynx, the most important case being that of a flat plane of bone impacted in the upper part of the trachea. The laryngoscope revealed its presence, but its exact situation and direction were revealed by means of the X-rays, and the source of obstruction to

(a) Paper read and Demonstration given before the British Laryngological, Rhinological, and Otological Association, May 11th 1900.

the breathing was easily extracted by means of Morell Mackenzie's forceps.

Foreign Body in the Right Bronchus.—The patient, an adult, some years previous, had allowed a half-sovereign to slip from the mouth into the trachea. There was a history of very severe spasm in the region of the larynx, although it was assured that the foreign body had passed into the œsophagus and stomach. Three months afterwards similar spasm took place, but for a number of years there had been complete rest. On examining the chest, however, by means of the screen the foreign body could be seen, and a photograph was also taken. Nothing has been done for the patient, as he is meantime content to let well alone; but by means of the screen accurate diagnosis was at once obtained.

In a number of cases in the Glasgow Royal Infirmary I have been asked to see patients under the care of my colleagues suffering from traumatic lesions in the mouth and face, and by means of the screen or photography, I have been able to diagnose fractures of the jaw extending in to the nose, and these in cases where there was almost no displacement, the fractures being incomplete, the usual signs were absent.

Chest Lesions.—In quite a number of cases I have been able to make out enlargement of the cardiac area, both in acute and chronic affections, and of one case where the condition was accompanied by paralysis and slight interference of the larynx on the left side. A photograph is seen on the wall. The patient has since been carefully examined from time to time and the laryngeal condition no longer exists, no evidence of aneurysm or other mediastinal tumour has ever been obtained from any diagnostic standpoint.

Under my own care and also under the care of my colleagues in the Royal Infirmary, quite a number of cases of aneurysm have been detected, and some of them at a very early period of their history. Let me cite one of these cases. The patient was brought to me over a year ago with unmistakable hoarseness indicating early impairment of the function of the recurrent laryngeal nerve. His medical attendant, who brought the case to me, was suspicious of the condition of the chest, and the physical signs were not very distinct. The screen at once revealed a pulsating tumour in the middle and descending portion of the aorta, and at intervals this case was carefully examined. The patient was advised to give up business and take complete rest, while iodide of potassium was administered internally. Lately, his medical attendant has reported that while the aneurysm is still there of course, the voice has practically been restored, and the patient is exceedingly well, able to walk about, and in every way seems much better than when we first saw him. Early diagnosis in this case, with complete rest, in all probability has had something to do with the satisfactory result. This is by no means a solitary case. I could quote others in which diagnosis has been made at an early period of the disease with equally satisfactory results.

I have also seen a number of cases of malignant disease in the thorax where the screen revealed conditions which put the diagnosis beyond doubt, and that when the only indication in the practically perfectly healthy person was the slight difficulty in swallowing. Mediastinal glands I have also made out on the screen both in children and adults. In one case the difficulty in breathing was marked, and the pressure could be seen to be the result of a tumour at the lower end of the trachea. From this condition the child gradually improved, and, with the change for the better, the shadows on the screen became less prominent.

Fluids in the region of the pericardium and the pleural cavities I have also detected.

Passing now to the question of phthisis, I may say at once that deposit at the apex of one or apices of both lungs I have distinctly observed, and have been able to confirm the diagnosis. I have now to speak with a certain amount of reserve, not because I think the subject cannot be pursued with interest, but the question of the lungs belongs more to the region of the general physician, and I have not had the same facilities offered as would justify my speaking of such conditions with the same amount of freedom as if it were in our own special department. Nevertheless, those who are interested in this will find something of interest in the work of Bouchard and Claude, of Paris. These gentlemen presented a long report on the application of the Röntgen rays at the Congress on Tuberculosis, recently held in Paris. A *résumé* of the work will be found in the third volume of the "Archives of Röntgen Rays," p. 36. There it will be seen that these observers claim that the shadows seen on the screen differ at the outset of the disease. With confluent pulmonary infiltration there is almost complete opacity. They observe that lobular infiltration and lobar infiltration differ in their densities. Cavities reveal themselves sometimes by absolute opacity and sometimes by zones of relative transparency, surrounded by spots of variable opacity. The authors conclude by stating that the X-rays make it possible in certain cases to discover commencing changes in the lungs at a period when other clinical investigations give no indication.

I am showing upon the screen an interesting case of abscess in the region of the upper part of the thorax, which was under the care of my friend, Professor H. E. Clark, of the Glasgow Royal Infirmary. A photograph was taken by the working electrician in the infirmary under the most difficult conditions. The child's breathing was so bad that it would not remain in any position long enough to allow of a satisfactory radiograph to be taken or to allow of a prolonged examination by the screen. Nevertheless, by both methods it was observed sufficiently, and although the photograph is not a very satisfactory one, it is worth while showing for the reasons above indicated. The swelling extended from the region of the neck to the upper third of the sternum. The larynx, as seen with the laryngeal mirror, was practically normal, both cords being perfectly white. It was quite evident, however, that the condition was due to pressure on the trachea. Dr. Clark and I agreed that tracheotomy was the only thing to try, but the child as may be judged, being only two-and-a-half years of age, and having suffered much from the acute illness of three weeks' duration, the operation was not very promising. After warning the parents, Dr. Clark operated. The insertion of the tube into the trachea not only did no good, but as we were afraid beforehand, completely stopped breathing. Under the circumstances, therefore, and considering the reports, Dr. Clark dissected carefully down towards the upper part of the thorax, inserted a probe, and was fortunate enough to come across a collection of fluid pus in the upper part of the mediastinum, which was evacuated.

The examination of the cavities of the face upon the screen has revealed some very important facts to me. First of all, by means of the mouth screen, which I described in my last demonstration, I have made differences in density between the two superior maxillaries. It must be admitted, however, that with the transillumination of the ordinary electric lamp, the same condition would have been revealed, and probably in a better degree, but in injuries of the

bones surrounding these cavities, it is different, as these could not have been detected by the transillumination. One can detect the passing of probes into the frontal sinus through the infundibulum, a fact of great value when treating cases of disease of the accessory cavities.

When mentioning the above instances of the application of the X-rays, I wish it clearly understood that in every instance all other methods of diagnosis were also carefully applied.

In conclusion, I would plead for the systematic examination of cases with the X-rays in order to obtain accurate information as to the relative value of these and other methods of diagnosis. In the majority of traumatic lesions, aneurysm, malignant disease, glandular enlargement, fluid effusions, deposits in the lung, &c., other signs are, as a rule, present, and the shadows obtained by the X-rays have therefore only a place among the different aids to diagnosis. In a minority of cases—let us frankly put it, in a small minority of cases—I have been certainly able to obtain information which otherwise could not have been obtained, and that in cases which had not only been examined by myself but also by others. The rays have a place, and one gradually increasing in importance—more than this I do claim for them.

Apparatus.—Cells, Wimshurst's machine, coils, and a large number of interrupters, including mechanical, mercury, Wehnelt (and modifications), with special reference to Macintyre, Wehnelt, Caldwell, and mercury jet forms, dischargers, a variety of Crooke's tubes, special apparatus for making the same containing different vacua, fluorescent screens for direct vision or reducing exposures, accessories for facilitating the taking of photographs in the region of the head and thorax, ordinary and stereoscopic photographs of (a) hard tissues, and (b) soft tissues.

Hard Tissues.—(1) The study of the anatomy of the nose, antrum, and spine; (2) fractures and injuries of the nose and maxillary walls; (3) tumours in this region.

Soft Tissues.—(1) Enlargement of the heart; (2) transposition of the viscera; (3) mediastinal glandular enlargement; (4) malignant and other neoplasms of the jaw and chest; (5) abscesses; (6) collections of fluid in the thorax; and (7) deposits in the lung, &c.

Foreign bodies of different kinds in the antrum of Highmore, maxillary bones, nose, pharynx, upper respiratory tract generally, and œsophagus.

German Clinical Lectures.

"CEREBRAL EXERCISE" IN THE TREATMENT OF CERTAIN MOTOR DISTURBANCES

By Dr. FRENKEL,
Of Heiden.

It is a fundamental property of all nerve substance to retain some trace of every influence acting upon it. When the same functional process is frequently repeated, the nervous apparatus undergoes a lasting change, which in the domain of association of ideas is manifested by the phenomena of memory, and in the sphere of motor functions permits of readily executing coordinate movements. This accounts for the physiological rôle of habit, education, training, and exercise, by means of which we learn to execute more or less automatically a large number of most complicated muscular movements, forming the basis of our animal life and of professional skill.

The mental or psycho-motor element obviously

plays an important part in the production of these coordinate movements. It implies idea or representation of the object aimed at by certain muscular contractions, effort of will required for their execution, and consciousness of the movement executed.

It is self-evident, without entering into an elaborate discussion of this subject, that the same exercises, which serve for the physiological education, so to speak, of our motor functions, may also be utilised for the therapeutical re-education in cases of motor disturbances, supervening in the course of various nervous diseases. This re-education is greatly facilitated by the functional substitution, in case of necessity, of various centres and cells of the nervous system for others.

Such are the physiological facts on which I have built up a system of treatment, successfully employed for several years for the relief of certain motor disturbances, such as paralysis agitans, Sydenham's chorea, convulsive tic, and aphasia.

This method consists in subjecting the affected muscles to graduated, systematic exercises, which necessarily exert an influence on the various nerve centres presiding over these movements. It may therefore fairly be described as *cerebral gymnastics*.

My procedure for the treatment of tabetic ataxy is as follows:—

I first determine as accurately as possible the degree and extent of the motor incoordination, that is to say, I do not simply ascertain the existence of ataxy of the lower or upper limbs, but I also endeavour to determine whether this ataxy manifests itself in the same manner or differently in the articulatory movements of the hip, knee, and foot; the peculiarities of its extension to various groups of muscles; whether or not it presents the same intensity in both limbs, &c. I then endeavour to decompose the ataxic movements as a whole into their simplest elements, and it is the latter that I first try to influence by a series of graduated exercises, in which the attention and will of the patient are largely brought to bear. I then gradually pass to exercises requiring more and more complicated movements, regulated according to the conditions existing in each particular case.

Generally speaking, these exercises consist of rather simple rhythmic movements, such as touching alternately the fingers of each hand, circumduction of the foot in a circle drawn on the floor, walking along a straight line, also traced on the floor, designing geometrical figures, picking up one by one small wooden discs or other small objects, &c. For these exercises may also be used a variety of appliances, which it is easy to devise and construct so as to answer to the requirements in each case.

It is indispensable to combat the ataxy of the muscles of the trunk, though these are almost entirely neglected in the usual treatment of tabes, in spite of the fact that they play a very important part in the disturbances of locomotion.

The results obtained by this method of treatment naturally vary greatly in different subjects. Sometimes they are remarkably good, as was the case, for instance, in a female patient in Professor Raymond's wards whom he permitted me to treat.

This patient suffered distinctly from tabes, with marked ataxy of the lower limbs and trunk. For seven years she had been obliged to keep her bed, being completely unable to stand on her feet. At present she walks without a stick, and without the least trace of ataxic movements. She is able to walk up and down stairs, go out in the street, and get in and out of a carriage, exactly like an healthy person, although she continues to present all the characteristic symptoms of tabes dorsalis, except ataxy.

In other tabetic patients the results obtained from

my method of treatment have been less striking, though, generally speaking, superior to those obtained from suspension or any other of the older methods, the locomotor incoordination having invariably been considerably reduced.

The results in question cannot be attributed to spontaneous improvement in respect of the ataxy, which is frequently met with in tabes, for in the cases under my observation no general decrease of the incoordination was obtained, but simply improvement of certain definite movements, viz., those affected by the exercises to which the patient had been subjected. There is therefore no escape from the conclusion that a general therapeutical effect has been determined which, considering the persistence of spinal lesions in these patients, can only be explained on the assumption of a favourable influence exerted by this method of treatment on the functions of the brain. This view, moreover, accords with Jendrassik's theory of ataxy, according to which the motor incoordination of tabetic patients is due to disturbances of cerebral origin.

Parkinson's disease is another affection in which I have treated the motor disturbances by this method.

When a person suffering from shaking palsy is requested to contract voluntarily a certain group of muscles, one frequently notices a marked decrease in the rigidity, both of the muscles brought into action and their antagonists. The impression is thus conveyed to the mind that volitional contraction and muscular rigidity are different conditions of the contractile substance of the muscle, antagonistic to each other, so to speak.

If, instead of ordering the patient to voluntarily contract his muscles, passive movements are executed on the limbs, the rigidity of the muscles will be found to increase, owing to the traction associated with passive movements.

The causes of the motor disturbances and other morbid symptoms, observed in patients suffering from paralysis agitans, are by most neurologists located in the central nervous system, Parkinson's disease therefore being by them considered, not as an affection of the muscular system, but as a neurosis.

My own experience with this disease, however, has led me to a different conclusion. As a matter of fact, the onset of paralysis agitans, which first attacks definite groups of muscles, and the fact that all the morbid phenomena met with, including those of propulsion, are readily explained in their slightest details by disturbances in the muscles of locomotion, point to the affection being of peripheral origin. The cerebral symptoms existing in these patients may be regarded as being of reflex origin.

My treatment of the motor disturbances in Parkinson's disease consists in the patient's endeavouring to contract the most rigid muscles during one or several sittings daily. These muscles, as a rule, are: in the legs, the calf muscles; in the trunk, the flexors of the spinal column; in the neck, the sterno-cleido-mastoids; in the upper limbs, the flexors, &c.

Under the influence of systematic exercise, the muscular rigidity gradually become attenuated. Patients who for years have been confined to their bed, unable to move, acquire the power to rise, walk, move the head, and write fairly well. In proportion as the spinal column straightens out and the patient learns to support himself on the sole of the foot in walking, the so-called propulsion phenomenon disappears, this being due, as is well known, to the difficulty experienced by the patient in keeping his equilibrium on account of the fixation of the trunk and the contracture of the foot in equino-varus, which obliges the patient to "run after his centre of gravity."

It remains for me to refer to some trials which I

have made with this method of treatment in chorea and convulsive tic.

Although these affections differ from each other in their symptoms, and probably also in their causes, they have in common associated spasmodic movements, produced in groups of muscles. Each disease, however, calls for different exercises.

The treatment to be adopted in Sydenham's chorea will be best illustrated by a severe case of this affection which came under my observation in a girl, *æt.* 14. She was very weak and suffered from continuous choreic spasms of a severe nature. I first wrapped the patient up entirely, as far as the neck, in a moist sheet, on top of which I applied several blankets, so that she was unable to move hand or foot. After a short period of extreme agitation, I had the satisfaction of finding that she got sufficiently calm to take some food. For a week the patient was thus wrapped in a moist sheet every day for four or six hours. This treatment exerted a sedative influence, not only on the choreic movements, but also on the mental condition, as was shown in various ways, among others by the patient becoming able to sleep.

When there was sufficient improvement in the choreic attacks and inanition, I began the exercises destined directly to counteract the existing motor disturbances. I first ordered the patient to execute the same movements which resulted from the choreic spasms, endeavouring to transform the involuntary muscular contractions into voluntary movements. The effect of these exercises was soon manifested by a marked decrease in intensity and frequency, and ultimately complete disappearance of the choreic movements.

In convulsive tic, while endeavouring to induce the patient by voluntary efforts to render the spasmodic movements less frequent, I pay particular attention to determining energetic contraction of the muscles, antagonistic to those implicated in the spasmodic phenomena. To increase the intensity of these contractions, I establish a resistance to the movements ordered, which can only be overcome by considerable effort. The results of this treatment have been sufficiently favourable to justify the hope that recent cases of tic may be cured in this way, and considerable improvement obtained in long-standing cases of this affection.

My method of treating motor disturbances is therefore applicable in a large number of cases, but it has also its limitations. It is, indeed, obvious that no benefit can possibly be derived therefrom, unless the subcortical and spinal organs of transmission are intact. When these organs are diseased, the treatment is powerless, and sometimes it is even contraindicated. In cases, for instance, of myelitis, multiple sclerosis, and spasmodic paraplegia, in which I have had recourse to the treatment in question, the effect was *nil*; I even not infrequently found aggravation of the morbid symptoms presented by the patients, under the influence of their fruitless efforts at determining voluntary movements.

The same remark holds good of cerebral hemiplegia, as soon as the contractures supervene which indicate the appearance of descending degeneration. Possibly, however, in such cases another means of influencing the motor disturbances should be resorted to—viz., reflex stimulation. It might, perhaps, also be possible to prevent secondary degeneration from making its appearance by stimulating the collaterals of transmission. In this connection I may mention an interesting fact told me by Prof. Eichhorst (Zurich)—viz., that contractures may be averted in hemiplegic patients by having recourse, immediately after the epileptic stroke, to massage, and also to passive, and, as far as possible, active movements of the affected limbs.

PERSONAL EXPERIENCES OF GOUT TERMINATING IN ACUTE MYOSITIS OF ENTIRE LEFT LOWER EXTREMITY.

By ANDREW SCOTT MYRTLE, M.D.Ed., J.P.,
Harrogate.

MEDICAL men seldom record their own experience of any ailment they may have suffered from. This is a matter for regret, as they might throw some new light on the symptoms and results of treatment of their own cases. It is with this impression I now offer the following remarks.

Many years ago a heavy hunter fell with me whilst crossing a pavement. My left knee was severely crushed between his body and the flags; since then the knee has frequently caused trouble in the way of constant aching, with effusion into the joint, and during the last four years has shown marked gouty symptoms.

In 1894 I had irritability of the bladder followed by prostatic mischief, leading speedily to the regular use of the catheter. In 1895 I suffered from ptomaine poisoning from eating a portion of partridge. For 18 months after this I had persistent gouty dyspeptic trouble, acidity, flatulence, constipation, anorexia, and mental as well as physical depression. In October, 1896, I was seized with sudden pain in the neck of the bladder, micturition became frequent and painful, and only a few drops were passed at a time. My son pronounced it gout, a distinguished surgeon stone. He introduced a sound, but on very careful examination could find nothing. The pain caused by this was most severe, but in a very short time it left me and was followed by great relief, and I could pass water more easily and retain it for longer periods than I had been able to do for many months.

A few days after the introduction of the sound, cystitis set in. For three weeks I passed large quantities of mucous pus and occasionally blood. Injections of boric acid and the internal use of salol cured me of this, but from the time when my prostate began to trouble me I had not only to resort to the catheterism constantly, but in order to enable me to go on with my work and to relieve me of the intolerable nuisance of frequent micturition, I had recourse to hypodermic injections of morphine. After over a year's injections, thrice in the 24 hours, they produced hard white nodes, very painful and persistent, so that my arms presented a conglomeration of hills and valleys making the use of the syringe impossible. I then took the morphine by the mouth, and have continued its daily use; I now consume 5 grs. in the 24 hours, not only without the slightest inconvenience, but the greatest comfort.

On Nov. 7th, 1899, I went to bed in my usual health; at 4 a.m. on Nov. 8th I awoke with a sharp pain in the left adductor longus; on rising to see what was wrong the pain was so severe I had to resume the reclining posture at once. At 9 my son saw me; he found the entire left extremity from the hip to the ankle swollen, hard, and painful; there was no redness, no pitting on pressure; the swelling was tense, the skin on the stretch; there was nothing amiss with veins, lymphatics, or glands. I bore deep pressure over the course of all vessels, but the slightest on the muscles caused me to wince. He said he had seen nothing like it, nor had I. It was clearly an attack of gouty myositis. I was put on colchicum, lysidine, and potassium citrate; I took these regularly every four hours for three days, when the acute pain left me.

On the morning of Nov. 12th I found great fullness of the left hip, from oedema. This extended from the crest of the ilium round to the spine, sacrum, and buttock, with deep pitting on pressure. The effusion

could be traced down outside the thigh to the foot, but there was none on the inside of the limb. The muscles continued hard, painful on pressure or slightest movement. The whole extremity was found three inches larger in circumference than its fellow. There was no constitutional disturbance, and as long as I lay on my back I was tolerably easy.

I now had recourse to the Greville electric hot-air baths. I took three thigh and leg baths at 260° F. for thirty-five minutes, and then three full-length baths at 360° F. for the same time. The tension was then relieved, the hardness softened, and the oedema removed, thereby enabling me to move a little without pain. Eczema now appeared, with intense itching. Knowing something of hay-flower baths I took six in my own room (98° F.), as I could not go to our sulphur water baths, and remained in for thirty minutes. These caused profuse perspiration, and completely cured the eczema; they also had a very marked influence in softening the muscular hardness of the hip and thigh, but below the knee matters remained the same as they had done for six weeks. I was now able to walk for a few minutes, but then all the muscles of my back and legs began to ache, ending in lumbago, threatening of sciatica on both sides, and acute pleurodynia on the right side. Various applications were used, and alkalies with potassium iodide and colchicum taken without much benefit. I then took anti-arthritis, 16 grs., thrice a day; on the second day I found my face flushed, I had frontal headache, my heart intermitted, and I had a sense of sinking at the epigastrium, symptoms which I had observed on all occasions when any of the coal-tar preparations were taken. I reduced the dose by one-half. This dose was not followed by any unpleasantness, and relieved me very quickly of all pain. The thing that struck me most was its powerful action on the kidneys, and with this increase I noticed that my bladder was much less troublesome, and could retain a much larger quantity, and for a much longer period than it had done for years. I did not require the catheter at all during the day, and only twice during the night. Before taking this remedy I had to use the catheter at least thrice during the day and three or four times during the night, and now, after four months, I find, although I require the catheter during the night, I seldom need it during the day.

During my long illness the urine never showed any uratic deposit or crystals, and only on two occasions was it a little thick and cloudy. At first I was kept on low diet—slops, in fact. This did not suit me; it brought on acidity, with great flatulence. I therefore changed to animal diet, with dry toast, and had my usual allowance of whisky (three glasses a day). The dyspepsia now left me, and I began to pick up. One remarkable feature was that throughout I never showed any constitutional disturbance; my pulse never varied, my temperature was never taken. Early in February I found I had lost flesh; the arms, chest, and right leg were greatly wasted, but I was much astonished to find that I weighed 4 lbs. heavier than I had ever done; this was evidently from the condition of the left leg. Towards the end of February my thigh had diminished to such an extent as to permit of examination of veins and lymphatics, but all were perfectly normal; below the knee the muscles remained hard and swollen as ever. On getting up in the morning the leg was the same size as when I lay down at night. On attempting to walk all my muscles failed me. Not only was there loss of power, but they were very sore. I now went in for a course of electric baths (constant current), and these were followed by the interrupted current passed from spine to all affected muscles. It was interesting to note the behaviour of the muscles under the treatment; those

of the left thigh and leg withstood a current that made me shout when applied to healthy muscle. Gradually the deadened fibres began to twitch, then contract and show signs of life. After ten baths I had lost most of the œdema, had gained power, could walk a mile, and considered myself well.

Dr. Eddison and Mr. Mayo Robson, of Leeds, Dr. Neville Williams, my son, and self agreed that we never had seen a similar case. Thrombosis, superficial and deep, and obstruction of lymphatics were discussed, but from the first no vein showed any sign of inflammation or obstruction, and there was no knotting of lymphatics or glandular complication. If the condition is to be attributed to obstruction of the vascular system, how is the position of the œdema to be explained, beginning as it did above the hip, passing round to the spine and down the outside of the whole of the thigh and leg to the foot, but not showing at all on the inner surface? For months before Nov. 7th I felt uncomfortably hot, broke into sudden perspirations without cause, and could not get enough fresh air. My idea is that gout had been silently at work for four months, then it broke out with violence, invading the cellular and muscular structures of the entire left lower limb, but avoiding joints, tendons, and vessels. Had such a burst taken possession of any internal organ I have little doubt it must have proved speedily fatal.

A PLEA FOR A MORE GENERAL USE OF WATER IN DISEASE.

By SIMON BARUCH, M.D.,

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THE rational application of water in disease originated in England, the first book on the subject, being written by Floyer in 1697. His "Psychrolusia" was translated into several languages. Its brilliant scholarly presentation of the subject induced the then most eminent physician on the Continent, Prof. Freidrich Hoffman, of Heidelberg, to visit England, and later to teach hydrotherapy so industriously that it was diffused into France and Italy, where it has been as permanently established as in Germany. A century later another English physician reported on the "Effects of Water," giving such excellent clinical proofs of its value that his book was translated into several languages, and his practice—affusions with cold water—introduced into the Vienna Hospital by Professor Joseph Franck. Thus Carrie's method became the real precursor of the now famous Brand method which aims by friction to prevent the depressing effect of the cold, and which makes its anti-pyretic effect secondary to the nerve stimulus. Despite the fact that several other eminent English physicians, Pitcairn, Cheyne and Huxham, had also written favourably of the water treatment, its use in acute and chronic diseases has made little progress in England, if we may judge from the recent literature on this subject. Among the recent advocates of hydrotherapy are men like Traube, Leyden, Kussmaul, Erb, Finburger, Senator, Baginsky, Vierordt in Germany; Charcot, Dujardin-Beaumez, Robin, Hutinel, Jubel-Remy, and Glenard in France; Nothnagel, Krafft-Ebing, Monti in Austria; Semmola, Cantani, Vinay, Maggiora in Italy; Draper, Delafield, Jacobi, Peabody, Osler, J. C. Wilson, Tyson, Peterson, Putnam of Harvard, in America. I have purposely omitted names like Winternitz and others who have made hydrotherapy

a speciality, because it is the purpose of this article to plead for investigation of the remedial properties of water from a modern clinical standpoint, as practised in the great hospitals and taught by the ablest teachers of medicine in Germany, France and America. With this purely practical aim in view, I shall consider:—

1. What are the causes of the present lack of appreciation of hydrotherapy?

2. What are the claims of hydrotherapy to the acceptance of physicians?

3. What are the clinical proofs of its claims to the confidence of the practitioner?

1. The chief causes of the desuetude into which water, as a remedial agent, has fallen are its espousal by lay people and empirics, and the absence of any reliable instruction on the subject in the medical schools.

After Dr. Floyer had published the book whose fame had reached the entire civilised world, the lay public did not fail to obtain a knowledge of it. His eloquent and scholarly plea aroused in the intelligent lay mind a high appreciation of the simplicity of the remedy, and an exaggerated estimate of its value. Seemingly to require no medical training, the water treatment rapidly became popular among lay people, some of whom, doubtless animated with a desire to propagate this simple and effective method of treating many diseases with the honest purpose of benefiting suffering humanity, while others, much more numerous and sordid, discovered in this highly praised remedy a source of pecuniary advantage which stimulated their zeal to an extraordinary degree. A few years after Floyer's publication there appeared a book written by Hancocke, an English clergyman, entitled "Febrifugum Magnum, or Common Water the Best Cure for Fevers." The fact that this book reached seven editions in one year warrants the belief that its influence among the public was enormous, and that its improper application in all sorts of cases became more and more frequent. In proportion to the abuse of this valuable agent by the lay public, medical men became estranged from it, because they discovered the evils wrought by its senseless and indiscriminate use. Despite the fact, therefore, that its judicious application according to Floyer's teachings (which were intended only for physicians) would have been, judging from our present more enlightened standpoint, far more rational and commendable than the bleeding, purging and vomiting practice of that day, water did not obtain a foothold among physicians. The quackery arising from its abuse was the more obnoxious to English physicians, because the dignity of their calling had but recently been enhanced by the appearance of the philosophic Sydenham, a man whose advanced medical thought may be fully appreciated to-day, when we read that, despite the violent spoiliative treatment which he observed everywhere, he taught that "disease is an effort of nature to preserve the patient," and that "a regular system of management frequently cures many diseases better than the powders of the apothecary." Had this leader of medical thought not found so many other sad errors to correct, he would probably have investigated and appreciated the value of water as a remedial agent with his characteristic philosophic acumen. Hydrotherapy would then have become a permanent acquisition in England. The aversion of medical men was natural and pardonable, because the use of so simple remedy as water was quite contrary to the heroic and complicated therapeutic methods in vogue. Their opposition, too, was seriously enhanced by the fact that quack doctors, drawing inspiration from the writings of Hancocke, arose on every side, who made active propaganda for mercenary purpose. That water again fell into dis

use is therefore not remarkable. One hundred years after Floyer, the famous Priessnitz, a peasant who, convinced of the remedial value of cold water, became the greatest enthusiast, and constructed a systematic hydropathy which seems to have survived better than the hydrotherapy of the doctors. Among the numerous foreigners attracted to his Silesian retreat were many persons of high social standing in England, who returned to their own country full of enthusiastic praises of hydropathy. Sir Edward Bulwer Lytton contributed an article to one of the English literary journals, in which he descanted in his usual graceful style upon the merits of hydropathy, to which he attributed his restoration to health after failure of the most eminent practitioners of London. Similar articles became quite abundant, and these stimulated the desire of the public to investigation and frequently to adoption and earnest propaganda. Physicians now began to adopt hydropathy, and to construct establishments for its practice in chronic diseases. So strong was the prejudice of the regular profession, however, that these men were ostracised as medical pariahs; a position from which the more catholic and liberal spirit of the present time is gradually emancipating them. The blighting effects of the espousal of water by laymen has been so pronounced in England, because its medical men are conservative, prudently avoiding practices at variance with those sanctioned by long usage, a mental quality most commendable in our profession. Much of the antagonism of the latter was due to the medical hydropaths, who, though obscure practitioners, became embittered by the animosity they encountered, and regarded themselves as martyrs to their convictions, and heaped abuse upon the spoiliative method of their opponents.

Thus has it come about that many physicians still look askance upon water as a remedial agent, and that they either regard it as akin to quackery to apply it, as inimical to them and their patients' interests, or as so simple that it demands little attention to details or methods. This attitude of English physicians is clearly exemplified by the sparseness of their contributions to the literature of the subject. In carefully looking over the *Index Medicus* for a period of 20 years, I find that during the past 20 years, only *four* brief articles have appeared from the pens of physicians residing in Great Britain, and that these furnished as clinical proof only *seven* cases on general hydrotherapy, while upon that important branch—fevers—there are only nine articles, furnishing four cases. The *Army Medical Reports* from 1859 to 1899 contain a report of two cases. (a) Of 54 articles on this subject during the past three years only two are from the pens of physicians residing in England. Is it fair to the practitioner, or just to his patient, to allow this valuable agent to remain in the hands of the medical and lay hydropaths? Shall we not rescue the remedy introduced in this country by Floyer, and advocated by Pitcairn, Huxham, Cheyne, Currie, Wright, and others, practised by the most eminent physicians elsewhere from the hands of the quack and semi-quack. This may be accomplished by more careful attention and investigation. The methods of application of water in disease should be taught in the schools and hospitals just as other remedial agents are taught, for its principles demand careful study, and its practice thorough training and observation, as I shall show. Kussmaul, Vierordt, and Vogl have, like Winternitz, emphasised the crying need of such instruction in recent articles. In Vienna Winternitz occupies a special chair of hydrotherapy,

and teaches it in his *Poliklinik*, as does Vierordt, who is not a specialist, in the Heidelberg Clinic.

Outside of these schools medical students are not afforded an opportunity of becoming sufficiently familiar with the methods of using water in disease to encourage their application in practice. This may be accounted for by the woeful lack of knowledge of the subject even among well-educated physicians. I have in mind a capable teacher of therapeutics who ten years ago opposed the Brand bath in typhoid because "he had seen his senior physician kill a woman with the cold bath." Inquiry elicited the fact that the "cold bath" consisted of wrapping the patient in a sheet and sprinkling ice water upon her until the temperature fell. It may illustrate the necessity of instruction to refer to the fact that such a method is entirely opposed to the principles of hydrotherapy, which demand that early reaction shall follow all cold procedures. In this instance the blood was driven from the surface vessels by the continuous cold sprinkling, the inner vessels again became congested and the action of the heart was embarrassed. If friction had been practised wherever the cold water is impinged upon the body, and if the temperature had not been so low (iced), but adapted to the case (65° — 70°), both of which are cardinal elements of the successful Brand bath, reaction would have ensued, dilating the cutaneous vessels and relieving the heart by the restoration of their lost tone. The patient would have been refreshed by each bath, and the case would probably have terminated differently. It is gratifying to note that this teacher became a convert to and is now an earnest advocate of the Brand method. His students will reap the benefit of his experience in typhoid fever; his instruction in the hydrotherapy of other diseases, especially in chronic cases, will, it is hoped, pass through a similar beneficent evolution.

Another eminent teacher thus describes the use of neurasthenia, in one of the volumes of the "International Clinic" series, as follows:—"The top of the head and the nape of the neck are points of attack. Have the bath tub one-third full of lukewarm water, so that the patient may stand in it without getting chilled; then if the bath has a douche attached, you may allow the shower to play on the top of the head and then down the nape of the neck; or you can slap the nape of the neck and the spine with towels wrung out of very cold water, &c. Nothing produces so good an effect on the nervous system as the trickling of cold water." This is a good illustration of how not to order cold water, because the temperature of the cold water and the very cold water are entirely left to the discretion of the patient, as are the duration. Trickle cold water over the spine is chilling and not adapted to evoke reaction; playing a cold douche over an excitable neurasthenic would irritate him, while the depressed patient would be stimulated thereby. I am glad to state that in a recent work this gentleman gives more definite directions for hydrotherapeutic procedure.

2. What are the claims of hydrotherapy to the acceptance of the medical profession?

First and foremost its advocates do not, like their imitators, the professional hydropaths, claim that it is a universal remedy, but that water is one of the most valuable therapeutic auxiliaries, to be applied in conjunction with diet, exercise, rest, massage, medicinal agents, with precise attention to the indications of each individual case. In this respect it differs from hydropathy, which is an empirical application of water, and which should therefore pass into desuetude among physicians. Secondly, it is claimed that the use of water in disease should be as carefully adapted to the patient's re-

(a) Dr. Vogl, medical director of the Bavarian Army, has published the records of over 8,000 cases to prove the vast advantages of the Brand method, and the Surgeon-General of the German Army has directed special attention to it.

quirements as are medicinal and other agents, like diet, electricity, &c., and that in each case the history, if reported, should state the procedure applied, whether ablation, affusion, full bath, half or hip bath, or douche, the temperature, duration, and in the latter the pressure being distinctly stated, just as is done in other prescriptions. We do not direct a patient to obtain a dose of quinine or calomel or strychnia from the chemist, but state the exact dose, mode of preparation, and time of administration. Water should not be ordered by telling the patient to take a hot bath or a cold bath or douche, but definite procedure should be ordered. Thirdly, no remedial agent is entitled to the confidence and acceptance of physicians unless it fulfils the following conditions:—

1. It must be readily obtainable.
2. Its action must be capable of explanation upon accepted physiological principles.
3. It must be easily graded by varying the dose.
4. Its clinical results must be sufficiently well established.

Does water fulfil these conditions?

1. That it is readily obtainable, goes without saying. Indeed, this is one of its chief recommendations. Moreover, it may be obtained in the solid, liquid, and vaporised form, each of which has special uses, thus making it the most flexible therapeutic agent.

2. To explain the *rationale* of the action of water in health and disease would require far more space than this article is entitled to. A few of the results of the physiological experiments upon which its action is based, must suffice here. Max Schneller has trephined a rabbit so as to expose the vessels in the pia mater. Seating the animal into a tub of cold water, he saw the vessels dilate; the brain substance rose through the opening and pulsed actively. Placing the animal into warm water, the brain sank down, the blood vessel contracted, and the rabbit became drowsy. This experiment demonstrates the hydrostatic effects of cold and warm water. By driving the blood from the surface the inner vessels became plethoric, by drawing it into the relaxed vessels of the surface the inner vessels became anæmic.

Many experiments have also been made by Winternitz, Loewy, Breitenstein, Thayer of Johns Hopkins, and others, to prove beyond doubt that cold procedure—baths, compresses, douches—produce an enormous increase in the red and white blood cells of blood taken from the lobe of the ear (a part not exposed to the cold), due doubtless to their having been driven to the surface from outlying districts. These observations have been confirmed by myself and assistants with the aid of the sphygmograph and Zeiss's hæmometer and other instruments of precision, so that "he who runs may read." Clearly that the circulation is under perfect control when cold and heat are applied judiciously, and not in haphazard fashion as is unhappily too prevalent, even among those who appreciate their remedial value. This control over the circulation enables us to control the secretions also. As an illustration I may cite the fact that an increase in the quantity and toxic quality of the urine is almost invariable under the systematic use of the Brand bath in typhoid fever. I have frequently observed an increase from a daily excretion of 30 to 40 ozs. to 80, 90, 100, and once even to 130 ozs. The elimination of toxic material which can be effected by the treatment is palpable. The effect of cold and heat, applied through the medium of water upon the enormous neuro-vascular supply of the skin, is readily appreciated. The *rationale* of the reflex effect of cold applied to the skin, for instance, is evident to the tyro in medicine even when he sees a fainting woman gasp after it, her face losing its pallor and the pulse returning to a

normal condition. It is plain that the excitation produced by the sudden impact of water much below (or above) the normal body temperature, is rapidly conveyed to the central nervous system and thence reflected upon the organs whose functioning capacity originates there.

3. The application of water to the cutaneous surface may be guided (dosed) with precision by changing its temperature (the range within safe limits being from 40° to 110° F.), as well as its duration and the mechanical, impact pressure (from one to 31 lbs.). An illustration of the effect of duration may be readily obtained by dipping the left hand into water at 40° and rapidly withdrawing it and applying friction. The result will be a reaction, by which the vessels will become full, the hand warm—a stimulated condition. Dip the right hand into the same water, and allow it to remain three minutes. The result (if the pain produced is borne) will be a contraction of the arterioles, and a dilatation of the vessels producing cyanosis, a depressed condition, to recover from which the most active friction will be needed. It is evident that by longer and shorter durations of the cold application varying effects may readily be produced. 3. The various changes in the technique, as full baths, half baths applied with friction, and hip baths, douches, enable us to vary the effect by mechanical impact. For instance, lying quietly in a bath of 60° for several minutes would be tolerated with equanimity by few persons; its effect would be depressing and chilling, while a douche of this temperature delivered with 21 lbs. pressure would produce an agreeable tingling, with immediate reaction and consequent stimulating effect.

(To be concluded in our next.)

Transactions of Societies.

BRADFORD MEDICO-CHIRURGICAL SOCIETY,
MEETING HELD MAY 15TH, 1900.

The President, Mr. W. HORROCKS, in the Chair.

DR. S. LODGE showed specimens: (1) Large tumour of occipital lobe, simulating cerebellar tumour during the life of the patient; (2) adenoma of thyroid isthmus; (3) glioma of retina. Photographs of cases: (1) Sarcoma of antrum which showed marked shrinkage after the injection of "Coley's fluid"; (2) epithelioma of orbit.

DR. BAXTER-TYRIE read notes on a case of

THORACIC ANEURYSM.

The patient was a man, æt. 51. The illness commenced about two years ago in the following way:—While engaged in valuing some stock on a farm he jumped about eight feet down into a field and felt "something give way" in the lower sternal region, and at once became faint; he was taken home, and an hour afterwards expected about a teacupful of pure blood. Physical examination revealed no abnormal signs except rhonchi at the bases of the lungs. There was no return of the bleeding, and after a few months he apparently recovered, although from time to time there was an irritating cough and some oppression at the chest. Five months ago œdema of the lower extremities was noticed; there was much wasting, and patient complained of a constant irritating cough and of dyspeptic symptoms. There was pain in the epigastrium passing through to the back, and at times extended round the body, following the course of the eighth and ninth dorsal nerves. There was accentuation of the second sound of the heart, otherwise the physical examination of the heart area showed nothing abnormal. There was no alteration in the radial pulses—no pupil change, no dysphagia and no alteration in the mobility of the tracheæ. A constant irritating cough was present, but there was no

peculiarity in its intonation. There was occasional paroxysmal dyspnoea with inspiratory stridor. From time to time small quantities of blood came up into the mouth without effort. The patient died suddenly, while in bed, from profuse hemorrhage. There was no autopsy.

Drs. KERR, CAMPBELL, and MAJOR discussed the case, and Dr. BAXTER-TYRIE replied.

Dr. E. H. CROWLEY showed specimens:—1. Tuberculosis of pharynx and larynx, with ulceration of the trachea. 2. Syphilitic ulceration of pharynx and larynx. 3. Brain of an idiot who died of acute tuberculosis. The old tuberculous focus, a mass of caseating gland in the mesentery, was shown. 4. Extensive atheroma of the aorta in a female. 5. Large infarct of kidney.

Dr. CROWLEY read a paper on

URÆMIA.

After remarking on the liability of persons of all ages and of either sex to attack, and on the varied forms which an attack may take, he proceeded to discuss the cause of uræmia. It was concluded that all cases of uræmia are due to the retention of some toxic substance or substances in the blood which should have been excreted by the kidneys. The poison may not be always the same, nor is its non-excretion necessarily due to renal inadequacy alone. A number of cases and groups of cases were then brought forward to illustrate some of the forms in which uræmia may occur. In regard to treatment, it was urged that preventive treatment is of the first importance in all cases in which it is likely or possible that uræmia may occur. Attention to the free action of the bowels and of the skin, together with regulation of the diet, are most important from the point of view of prevention. During a mild uræmic attack where there is much vomiting, the use of the enema of magnesium sulphate was advocated as being of great value. In using the hot vapour bath the danger was mentioned of prolonging it in cases where sweating is not soon induced. To promote sweating the careful use of pilocarpine in doses of one-tenth of a grain was advocated, the patient being first put into a hot pack and a copious draught of hot tea having been administered. In some cases of convulsions, in eclampsia, and where there is a high tension pulse, the withdrawal of 20 ozs. of blood is often followed by very marked relief. Lavage of the stomach was alluded to as a means of treatment neglected somewhat in England and likely to give beneficial results. The injection of saline fluid either directly into a vein or preferably into the loose subcutaneous tissues was favourably spoken of. The administration of morphia was only considered justifiable in very carefully-selected cases, possibly where there was restlessness and insomnia, and at the same time there was free action of the bowels and plenty of water being passed, the use of morphia might be beneficial. Morphia is contra-indicated where there is œdema of the lungs or pleural effusion hampering the pulmonary movements.

A brisk discussion followed the reading of the paper.

Mr. Wm. HORROCKS read a paper on "The Medical History of Gibbon, the Historian."

stethoscope is placed on any part of the vertebral column the heart beats will be distinctly heard. The cause of the phenomenon is evidently in the transmission of the sound by solid bodies (the ganglions).

CARDIO-SCLEROSIS.

Prof. Huchard, in speaking on cardio-sclerosis, said that tachycardia always accompanied the bruit or galop, it was thus that patients presented pulsations as much as 140 per minute, with a certain amount of œdema as the result of a hyposystolic condition of the heart, and frequently dyspnoea, which in his opinion proceeded from their mode of diet. Besides these patients suffer from insomnia because they cannot breathe properly. The best treatment was not to give sulphonal, chloral or other hypnotics, but to enjoin an absolutely milk diet, the result of that treatment is generally very favourable to the patient; the dyspnoea disappears and sleep consequently returns. It should be always borne in mind that when a milk diet is prescribed, the patient should be recommended to rinse his mouth with Vichy water after each glass of milk, otherwise, the particles of milk remaining in the mouth undergo a kind of fermentations producing trouble enough to oblige the suspension or suppression of the treatment.

The patients suffering from toxi-alimentary dyspnoea are almost always pale which, to the superficial observer, appears to be due to anæmia and is treated accordingly, to the detriment of the affection. This pseudo-anæmia should be treated not with iron nor by a substantial régime, but by milk and nitro-glycerine (1 per cent. solution).

HYPODERMIC INJECTIONS OF CAMPHORATED OIL.

According to Dr. Vaillant, camphor is a powerful cardiac tonic and an antispasmodic which deserves the first place among the drugs capable of giving the heart new vigour, and in every case where that organ suffered in the course of fever, injections of camphorated oil are inoffensive and act rapidly. But although non-toxic, it was needless to exceed the dose of fifteen grains of camphor in the twenty-four hours. The average daily dose of the oil solution (1—10) is from half a drachm to two drachms for an adult. In phthisical patients injections of the oil gave good results in modifying the bronchial secretions. The only counter indication to the treatment was pregnancy on account of cases of miscarriage attributed to the absorption of large doses of camphor.

France.

[FROM OUR OWN CORRESPONDENT.]

PARIS, June 10th, 1900.

TRACHEO-BRONCHIAL ADENOPATHY.

The difficulty experienced in diagnosing the existence of ganglions along the tracheo-bronchial tract is felt by every practitioner. The rational signs, though numerous and various, are not exactly characteristic and of which one only might be considered as conclusive—dulness over the third, fourth, and fifth dorsal vertebrae—is not to be perceived at the outset, and in any case requires a very delicate sense of sound on the part of the operator. Dr. Gerlier says that there exists a very simple sign which permits the perception of the increase in volume of the ganglions. If the

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, June 9th, 1900.

At the Congress for Medicine, Hr. Müller, Leipsic, read a paper on

THE ORIGINATION OF INFLAMMATION OF THE LUNGS.

Various results had been arrived at. At one time it had been assumed that the normal lung contained bacteria, these only required an injury to the lung to set up pneumonia. On the other hand, Friedrich Müller declared the healthy lung to be quite free of bacteria, and was of opinion that the invasion of infective bacteria took place in a roundabout way. He endeavoured to set up pneumonia experimentally by aspiration. It was found that bacteria never entered the lung through the epithe-

lium, but through a breach of surface continuity. It might be thought that the bacteria first acted on the epithelial surface of the terminal alveoli, but this was not the case, they were taken in through the surface and developed laterally towards the side. Exudation was present rather in the neighbouring alveoli than in the terminal alveoli themselves; there was therefore no surface action. The end zones in the alveolar exudation were rich in bacteria. The progressing patches in the lungs first became developed in the septa, and thence the infection passed to the lymph tracts. This was confirmed by the condition of the lungs in infants and adults after apoplexies. There was more difficulty in croupous pneumonia. One should not examine the visibly changed parts, but the lobes with commencing inflammation. These would be found the seat of alveolar oedema, small vascular pneumonic patches, situated in the most peripheral parts, with bacteria in the septa; thus in these very earliest periods bacteria were to be found in the lymph vessels, and not in the later stages only; the route being interstitial. At this period, also, there was lymphangitis of the pleura, giving rise to the pain. In the vague pneumonia of rabbits, the pleural lymph vessels were already flooded with bacteria. In aspiration and croupous pneumonia, therefore, the bacteria spread along the lymph vessels.

Hr. Wassermann, Berlin, followed with a paper on
RECENT EXPERIMENTS IN THE DOMAIN OF SERUM
THERAPEUTICS.

The speaker acknowledged that the results desired had not been obtained; antitoxically acting kinds of serum had indeed been discovered, which, biologically, had proved themselves to be specific bactericide serums, but therapeutically they had no power. Cholera and anthrax were examples of this. On the basis of the experiments of Ehrlich and Bordet, antitoxic and bactericide serums were distinguished, these two substances being necessary to a curative serum, being contained in the serum of immunised animals and in the normal organism. According to this view then it was easily comprehensible why there was no curative action when once the infection had passed beyond a certain degree. He then passed on to the classical experiments of Ehrlich, which furnished a new basis for practice. Two different substances were concerned which in a certain manner acted on each other: 1, immune serum; 2, terminal bodies or components, the latter a kind of digesting ferment, which strengthened the digesting power on the bacteria. This was contained in normal serum and was called alexine. The intermediary body was never present in the normal body but originated first in the immunising process. The bactericide immune-serum contained actually therefore nothing more than the intermediary body. For a curative action on the part of a serum we require: 1, a sufficient quantity of immune serum, 2, or a sufficient quantity of the intermediary body. If there was not a sufficient quantity of either of these substances, or if they did not, in Ehrlich's sense, act sufficiently on each other there could not be any immunisation. We should strive to extend the boundaries of curative action on the human subject, as it had already been done in animal experiments.

Hr. Ehrlich, Frankfort, confirmed the statements given, and said it might be years before theoretical results

could be realised in practice. In anthrax the immune body had not yet been found. He further showed how these bactericide serums often produced undesirable effects and did not act with certainty; dogs and horses were too far removed from the human subject to afford trustworthy data.

At the Dermatological Society, Hr. Caspar gave his views on the

TREATMENT OF GONORRHOEA.

He was very sceptical as to all recommendation of new remedies applied in the way of injection. All abortive treatment, whether strong injection of silver application of protargol, or Janet's washings, were to be rejected. No success could be expected, but complications, as the result of "abortive treatment" were frequent. The avoidance of any complication was the first aim of treatment. There must be no introduction of any instrument in the acute stage. He distinguishes gonorrhoea commencing with violent inflammation from that commencing without such symptoms. For the first he urgently recommended a 1 per cent. solution of thallin for injection. Frequent injections, lasting only a short time, were suitable. For the second category the so-called antiseptics (arg. nit. 1 in 10,000 to 1 in 4,000, and pot. permang.) were to be recommended. Protargol was less irritating than silver nitrate; it caused less pain, but it was not so effective. A change must constantly be made between antiseptic and astringent injections. General treatment and diet were very important. The drinking of large quantities of liquids, and the occasional use of balsamics were to be recommended. The latter indication was particularly in place in cystitis colli. Local treatment of the posterior part of the urethra (washing out with silver) should only come into use after weeks of the other treatment.

If chronic gonorrhoea developed, a special accurate diagnosis was necessary for its treatment. According to the speaker's statistics, out of 100 cases there was infiltrating urethritis in nine, chronic prostatitis in 80, in five infiltrating urethritis and prostatitis, and other forms in six. The small percentage of infiltrating urethritis cases was striking, but it agreed with the speaker's other observations. Prognosis in this form was not favourable, without treatment strictures were certain. The treatment was mechanical bougies—stretching and instillation of silver solutions. The large number of prostatitis cases was surprising. Careful examination of the prostatic secretion was important; in 30 cases he found but little, in 31 a good deal of pus, in 24 the secretion was pure pus. Gonococci were only found five times. The prostate was found enlarged by palpation from the rectum only in 16 cases. As regarded the treatment of the prostatitis, local massage was of the first consideration; electricity, electrolysis, local application of iodine and ichthyol; hydropathic treatment and operative measures (Bottini's) had not proved themselves useful.

In some cases all attempts to remove the symptoms were in vain. He distinguished those cases in which all attempts to find gonococci failed from those in which they were present. He found them in only 8 per cent. Examination of the morning urine was deceptive. In Von Ziemssen's klinik large numbers of threads had been found in the morning urine of patients who had not had gonorrhoea. Cases of bacterorrhoea were to be dis-

tinguished from gonorrhœa, they were incurable it was true, but quite harmless.

If in spite of treatment, the secretion and the filaments remain and no gonococci were found, treatment should be stopped. Aimless and useless treatment could only do harm and might lead to serious complications, and it might set up neurasthenia of a severe type. By the popularisation of medicine there was not only a gonorrhœophobia but a gonococcophobia. Polypragmasis was decidedly to be rejected.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, June 9th, 1900.

FACIAL WOUNDS.

WEINLECHNER, at the last meeting of the Aerzte der Gesellschaft, exhibited two patients with complicated facial wounds. The first was caused by a stab on the right side of the face, injuring the internal maxillary artery, which repeatedly commenced to bleed, in spite of energetic temporising. Ultimately, the wound had to be reopened and the artery ligatured. The second was that of a man with a bullet wound. The missile entered just under the right zygoma, passed through the palate, and had emerged close to the left side of the third cervical vertebra.

TUBERCULOUS PNEUMOTHORAX.

Schliessinger next presented a cured patient with a remarkable history. Four months ago the patient became very ill without any very obvious cause, and speedily developed grave symptoms in the left lung. After four months "*Liègeur*," no auscultatory or percussion abnormality could be found.

OSTEOMALACIA.

Latzko showed a female with osteomalacia, from whom he had removed an ovarian tumour with part of the adnexa without any improvement in the bone affection. He then decided to press the phosphorus treatment.

GONORRHOËAL NEURITIS.

At the "Medical Club," Kienböck exhibited a female patient, æt. 26, recently married, who had previously been perfectly healthy. Last summer, shortly after the wedding, she was suddenly attacked with urethritis. At the present time the muscles of the shoulder are greatly atrophied and shrunken, while the movements of the arm are greatly impaired even in passive movements. The subcutaneous tissue is much thickened, while the skin is quite cyanotic. Kienböck was of opinion that a gonorrhœal neuritis of the brachial plexus was the primary origin of the disease.

MULTIPLE PAPULES ON THE CONJUNCTIVA BULBI.

Schreiber presented a patient, æt. 21, who was admitted into hospital with eroded papules on the genitals, similar hard papules appearing later on on the conjunctiva bulbi. At first it was diagnosed as scrofulous conjunctivitis from its persistence, but the peculiar efflorescence raised a doubt that led to specific treatment, which caused them to disappear rapidly. It may be noted that this is a rare occurrence, only two others being recorded in medical literature.

DRUMSTICK FINGERS IN VITUM CORDIS.

Dothan showed another patient with drumstick fingers. She was a seamstress, æt. 27, and had suffered from insufficiency and stenosis of the mitral as well as

the aortic valves. At 14 years of age she had suffered from chorea, and on her recovery the cardiac lesion was observed. Several years passed by without any trouble or inconvenience until last year, when she had an attack of left hemichorea. Along with this she had great pain in the right side of the face and right leg, while the terminal phalanges of both hands underwent gradual thickening, with a feeling in them as if the skin were too tight for the underlying structure. At the present time the choreic movements are present, together with the drumstick deformity. The lower end of the right tibia was also enlarged. Donath considered this to be a case falling into the class described by Bamberger as osteoperiostitis. Swelling of the fingers is common enough in rheumatism or morbus cordis, a symptom which can be easily explained by the passive congestion in the lungs from the imperfect valves, but a periostitis can hardly be produced by such a cause. Donath thought the inflammation was due to some toxic agent, probably that which caused the morbus cordis and chorea.

PULSATION OF PAROTIDS IN MORBUS CORDIS.

Pauli drew attention to a very unusual symptom in a case of mitral insufficiency. Owing to the intense congestion, pulsation could not be observed in the veins over the liver and behind both ears. The latter were so swollen that the patient had every appearance of mumps. The pulsations were synchronous with those of the heart. The phenomenon disappeared under the administration of digitalis, but soon returned on its withdrawal. It must be understood that tricuspid insufficiency also existed which could be brought out with these experiments. The blood could be pressed from one side of the parotid to the other. Pauli is of opinion that there are a number of veins in the gland that are easily distended. He confesses that he has not hitherto seen this symptom described.

SPITTOONS ON THE FOOTPATHS.

Beck followed with a long paper on the prophylaxis in tuberculosis. He expressed alarm at the danger to the public of allowing tuberculous patients to expectorate on the pavements. In his examination on this subject he has obtained tuberculous bacilli from the dust of footpaths blown into the air. He has mixed tuberculous sputum with sand and dust, and after 24 hours drying cultivated the bacilli. He sees no other means of ensuring the safety of the public than to provide spittoons containing a one per cent. solution of corrosive sublimate to be placed in streets as well as in dwellings.

Hoff thought that this would be carrying science too far. He held that phthisis is not so easily transmitted if the diathesis were absent.

The Operating Theatres.

WEST LONDON HOSPITAL.

CYSTIC TUMOUR OF OVARY.—Mr. BIDWELL operated on a woman, æt. 37, who had a large tumour occupying the whole of the abdomen. She had borne two children, the youngest being three years of age. Two years ago she noticed some swelling of the abdomen, and she had gone to a hospital for diseases of women, where pregnancy had been diagnosed, the tumour had slowly continued to grow. A cyst, with well-marked thrill, could be easily demonstrated in the right

lower part of the abdomen, but in the upper part of the abdomen on the right side there was a freely movable body which felt very much like the head and body of a fetus. No cardiac sounds could be felt on the tumour. The abdomen was opened in the ordinary way below the umbilicus, a large amount of ascitic fluid escaping, and on examining with the hand the whole tumour was found to be ovarian. The lower cyst was evacuated with an ovarian trocar, and an attempt was made to evacuate the other cysts through the one opening; this, however, was impossible owing to the multitude of the cysts and the thickness of their contents. The incision was, therefore, prolonged up to the umbilicus, and the whole tumour turned out, only recent adhesions existed, which were easily separated, but it was found that a cyst had ruptured at the upper part of the tumour. The pedicle was tied after transfixing, and the tumour cut away; a ligature was placed on the ovarian artery. The intestines were all congested, and presented a granular appearance, evidently due to the irritating character of the fluid from the ruptured cyst. They were well cleaned and the pelvis was sponged out carefully. The peritoneum was then united by a continuous silk suture, which was passed from side to side through both edges of the peritoneum. A few interrupted points of silk suture united the rectus sheath, and the skin was united with silkworm gut.

Mr. Bidwell remarked that the case was interesting on account of the peculiar appearance and feeling of the tumour, although he admitted that the upper part of the swelling felt very like a fetus, he had expressed his opinion that the tumour, was simply ovarian. The resemblance to a fetus was found, on examination of the tumour, to be caused by the presence of two pedunculated portions of the tumour, one of which corresponded with the foetal head, and the other with the body. Although the greater part of the tumour was made up of innumerable cysts portions of it were solid. He also drew attention to his method of suturing the peritoneum, by passing each stitch from side to side, through, instead of over, each edge; each edge of peritoneum was brought accurately into apposition, the result being that no adhesions of intestine would form to the scar. He had verified the absence of any adhesions in several cases of pylorotomy, done in two stages, where on reopening the abdomen at the expiration of three weeks to complete the operation, no adhesions to the abdominal scar were found.

THE CANCER HOSPITAL.

TWO CASES OF OVARIAN TUMOUR.—Mr. CHARLES RYALL operated on a woman, æt. 40, who had been admitted into hospital with a tumour in the abdomen. She had suffered from pain in the right iliac region down the right thigh for six months, and this had become gradually worse. There was excessive loss at the menstrual period. On examination a round movable tumour could be felt lying in the pelvic, and a little to the right of the middle line and bimanually it could be felt through Douglas's pouch and the right lateral fornix. It seemed quite hard in consistency, and was no doubt an ovarian tumour. The patient having been anæsthetised, the abdomen was opened in the middle line above the pubes, and the tumour was with ease drawn outside the wound and removed. It proved to be a dermoid of the right ovary with a greatly

thickened cyst wall and the contents were hair and sebaceous matter.

The other case was that of a woman, æt. 43, who had also been admitted into hospital for an abdominal tumour, loss of flesh, dyspnoea, and pain. Three years ago she had great swelling of the abdomen, which her doctor thought was due to ascites, and, not believing that she was five months' pregnant, he tapped her, with the result that a great deal of fluid was drawn off, but she aborted of twins. She did not notice any tumour until three months ago, when she was delivered of a full-term child, now living, but she noticed that her abdomen did not appear to get much smaller, and her doctor then detected this tumour. On examination a tumour could be found rising out of the pelvis, extending into both that region and upwards to a point midway between the umbilicus and ensiform cartilage. It was fairly mobile, and seemed hard in some parts and soft and fluctuating in others. Bimanually it was not found to be intimately connected with the uterus. The patient being anæsthetised, the abdomen was opened in the middle line, and the length of incision had naturally to be extensive, in order to allow the tumour to be delivered through the wound and removed. The tumour was of the right ovary, and was cystic in some parts and solid in others, and showed all the naked eye characteristics of cystic sarcoma. The patient bore the operation without any marked shock.

Mr. Ryall said that these two cases showed how difficult it was to make an exact diagnosis of the nature of the tumour before operation. The dermoid cyst appeared so hard and solid that he thought it was an ovarian fibro-myoma, and the cystic sarcoma was diagnosed as a simple multi-locular cyst. The method of removing the tumours was the same in each case. The vessels in the pedicles were ligated after they had been exposed by turning back flaps of peritoneum, and these flaps were then carefully sutured over the ligated stump so as to leave no raw surface exposed. This was, he said, a necessary precaution to take owing to liability of adhesion taking place between the intestine and any pedicle uncovered by peritoneum, and this danger had been very forcibly brought to his notice some time ago, when adhesion occurred between the sigmoid and an unprotected pedicle in the left broad ligament with the result that the kinking caused intestinal obstruction a few days after operation and it was necessary to re-open the abdomen to find this and thus saved the patient's life. The abdominal wall in both cases was sutured in three layers.

Both cases made an uninterrupted recovery, and microscopic examination proved the second case to be sarcoma.

THE arrest is reported of the proprietors of a "diploma mill" called the Metropolitan Medical College, at Chicago, who have been instrumental in making physicians wholesale by post, especially, we are informed, in Great Britain, where candidates furnished with these degrees are said to have sought admission to the Army Medical Service, not, we imagine, with any measure of success. It is interesting to note that the proceedings were taken for violation of the postal regulations, and not on medical grounds.

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St. Pancras ratepayers. Indeed, the cost of main-
tenance in some of the best provincial asylums is far
less than nineteen shillings and threepence per head
weekly. The worst feature of the whole business, so
far as the public is concerned, lies in the fact
that St. Pancras has 1,600 lunatics, while a neigh-
bouring parish—Islington—with a larger popu-
lation, has only a little over 1,000. Certainly,
the officials of St. Pancras have offered inducements
all round for the capture of every pauper lunatic in
the parish. While human nature is in its present
stage of imperfection, it can hardly be wondered at
if lunatics are manufactured as well as discovered.
That such a state of things as the detention of sane
persons in lunatic asylums is possible in any part of
the United Kingdom at the end of the nineteenth
century will come as a startling revelation to the
community. So far as the facts are known with
regard to St. Pancras they do not warrant
such a conclusion; but at the same time
the fact of the undue proportion of pauper
lunatics chargeable to the parish, taken to-
gether with the corrupt system of certification,
will necessitate an instant and searching investiga-
tion into the whole matter. The first question that
naturally arises is how the Lunacy Commissioners
have allowed this state of affairs to escape their
notice. They are answerable for the administration
of the lunacy laws of the United Kingdom, and such
a fact as a disproportionate amount of lunacy in any
given district year after year should have been inves-
tigated upon scientific, if upon no other grounds.
The further facts that these patients were all sent
to two private asylums at exorbitant rates should
have engaged the earnest attention of any Board of
Lunacy Commissioners who knew their duty. This
affair, indeed, emphasises an old-standing suspicion
that the Lunacy Commissioners have gone the way
of most Government departments, and require
thorough overhauling and reconstitution. Their
methods of supervision are, to say the least of it,
cumbrous and easily evaded, and for that matter
they stand self-condemned by the mere fact that
such a state of affairs as that recently disclosed at
St. Pancras could have been going on for thirty
years without being discovered and rectified. Then
we come to the Local Government Board,
who have to control the expenditure of local
bodies under the Poor-law. Have none of
the inspectors of the Local Government Board noted
what was going on in the case of the St. Pancras
pauper lunatics? If noted, where are their reports?
If not so noted, where is their system? The more
one considers this scandal the more does the impera-
tive necessity of a public investigation become
apparent. An event of this kind shows that the evil
weed of corrupt vestry administration is not yet
rooted out of our midst, and there is reason to fear that
blackmailing is not confined to the relieving officer's
department. At St. Pancras the offenders, nine
in number, were severely censured by the
Board. We venture to assert, however, that

a mere censure fails to meet the requirements of the case. The position of everyone concerned in this most atrocious scandal must be minutely investigated. Incidentally it should be found out whether now or at any former period members of the Vestry have had any interest in the two private asylums whither the pauper lunatics have been sent. The pitiable weakness of the medical men who have consented to bribe the relieving officers will possibly result in the loss to the profession of all future fees for lunacy certification, as the proposal has been mooted for some time past that all pauper lunatic matters in the district should be under the care of a specially appointed expert in lunacy.

THE SPREAD OF THE PLAGUE.

THE gradual spread of the plague is exciting apprehension in various parts of the world, and the means of averting the importation of infection is occupying sanitary authorities generally. The disease is spreading along the shores of the Red Sea with alarming rapidity; it has obtained a firm footing in Egypt; and it is raging in countries as far apart as Manila and New Caledonia, India and Buenos Ayres, Sydney and San Francisco. In Sydney there have been some 300 cases, and the disease has claimed its victims at other Australian ports; in fact, its persistency in Sydney and its steady spread throughout Australia are among the most disquieting features of the imported malady. This fact alone proves that white races are not immune to the disease, though experience seems to show that they are less susceptible than Asiatics. Even good sanitation does not appear *per se* to afford an adequate safeguard against its introduction into a country, in fact it is now abundantly evident that sanitation of a special kind is required, the exact scope whereof has not been fully worked out. The recognition of the rôle played by rats in its dissemination is a fact of extreme importance, and displays in a clear and unfavourable light the pathological co-relationship of the lower animals and man. Instead of concentrating our energies on the discovery and trial of prophylactic and curative serums, we might possibly be more usefully engaged in studying the natural history of the disease and in endeavouring to ascertain precisely how and under what circumstances it is spread. As the recognition of the presence of the disease in our midst is essential to any successful attempt to circumscribe its spread the first step would naturally be to instruct practitioners of medicine in its symptomatology. As Professor Simpson recently remarked, a disease which may be mistaken for yellow fever, gastro-enteritis, typhus fever, diphtheria, influenza, syphilis, malaria, and parotitis is one in which diagnosis from clinical symptoms is by no means easy. In this respect the *New York Medical Record* has been well inspired in reproducing the main features of the circular recently issued by the department of health in Berlin which deals more particularly with the clinical symptoms. This circular places the number of forms

under which the plague presents itself as three—glandular, skin, or lung plague. In regard to skin plague it says: "Plague pustules and plague carbuncles are not frequent as compared with plague. They begin with a spot about the size of a flea-bite or a pea on some part of the skin. From this very painful spot there develops a blister filled with cloudy matter. It then either retains the character of a pustule or the surrounding tissue becomes hard and thick, later developing into a deep carbuncle and then into a burning swelling. Inflamed lymph vessels may convey the infection to the nearest layer of glands—in which then a bubo may grow. A bubo may also make its appearance in the neighbourhood of a carbuncle." Pneumonic plague is the most difficult of diagnosis. In some epidemics it is the most common form and generally closely resembles an ordinary violent catarrhal or croupous pneumonia, while on occasions it is extremely similar to other inflammations of the lungs. The Berlin circular says: "In all forms of plague the early appearance of heart weakness is noted, together with irritation of the stomach and abdomen, extreme sensitiveness to pressure in the region of the epigastrium and the cæcum, violent nausea, and later also the expulsion of black faecal matter. A slight degree of swelling of the abdomen is the rule; soft swelling of the spleen and traces of nucleo-albumin and serum-albumin in the urine, bloody vomit or blood in urine are less frequent. A diphtheritic affection of the tonsils is often found in the early stages." As matters at present stand the means at our disposal for dealing with the disease are mainly preventive. No specific has yet been discovered, and ordinary curative measures have but little influence on the course or termination of the disease. The therapeutic value of anti-plague serum is still unproven, although it would appear to be useful under certain circumstances. A course of lectures on this subject would not be out of place at the present juncture, if only to place medical men on their guard.

THE ROLE OF THE GONOCOCCUS.

SINCE the important discovery of the gonococcus by Neisser, cultivation of these micro-organisms and inoculation experiments on the human subject have conclusively proved that they are causal agents in the production of gonorrhœa. Neisser, in his recent paper, published in the *New York Medical News*, states that gonorrhœa is always an infectious disease communicated from one person to another. This is the view which is generally accepted in this country. At the same time, it must be confessed that the acquirement of the disease by this means is not such an easy matter as it may seem, especially in connection with the great class of chronic suppurative genital affections in women. Shrewd clinical observers and authorities in the past were compelled to conclude that gonorrhœa might arise in certain cases in women without apparent infection, and while admitting that when once developed it was propa-

gated by contact, they were agreed that it might arise *de novo* in the woman, the term *de novo* being used in the sense of promiscuous intercourse, irritative causes, decomposing seminal and genital secretions, excessive venery, drink, and inattention to cleanliness. For example, in this way Erichsen held that gonorrhœa—a highly infective inflammation of the mucous membrane of the vagina generated by the decomposition of retained semen and of foul discharges—was constantly developed *de novo* in prostitutes, that is, without infection from the male. In the last edition of his work, moreover, it is stated that gonorrhœa has its origin in the female, and is possibly developed in prostitutes without infection from the male. It is interesting to note that the apparent spontaneity of disease receives some support from clinical observation. Sir Douglas Powell is of opinion that a common cold may cause the conversion of quiescent pre-existing organisms into virulent and highly contagious ones. Again, it is well known that the bacillus coli, a normal inhabitant of the intestines, and under ordinary circumstances, harmless, may under various conditions take on virulent action. All these points have an important bearing upon the life history of the gonococcus. Dr. J. A. Shaw-Mackenzie, in the absence of direct clinical proof of acquisition of the gonococcus in certain cases in the female suggests the conversion of non-pathogenic normal inhabitants of the genital tract into pathogenic. In support thereof he alludes to the work of S. Lustgarten, who affirms that the normal male urethra is inhabited by a variety of micro-organisms. There is, for example, a special species of diplococci which resembles Neisser's gonococcus very closely in shape and form, and especially in being decolourised by Gram's method. The same uncertainty applies to pus obtained from the vagina. If non-pathogenic diplococci similar morphologically to Neisser's microbe, and differing very little in their cultures, have been demonstrated and exist in the vagina or in pus (Bumm), a diagnosis dependent upon such a basis is always open to doubt. Thus this observer favours the view that the gonococcus may not in the female always be due to transmission or the association of syphilis and gonorrhœa, but may be secondary to primary or secondary syphilitic contamination or other irritative cause. If this be so, it follows that the demonstrated presence of the gonococcus in any given case may not be pathognomonic of a pure gonococcal invasion, but dependent upon a syphilitic basis. Notwithstanding the immense importance of Neisser's discovery of the gonococcus and its propagation by contact both in the prophylactic and curative treatment of gonorrhœa, the saddest part of the picture is that when once the gonococcus has gained foothold in the uterine mucosa scarcely any medical treatment is of service, and in the absence of absolute rest for weeks or months, impossible in a hospital, laparotomy is inevitable. On the other hand, Dr. Shaw-Mackenzie, in urging the unrecognised syphilitic factor in many of these cases, has

long contended that while mercurial treatment is of no use in the purely local and acute cases of gonorrhœa, it is of great value in many of the chronic cases which drag on in men and women, and which may ultimately necessitate operative interference.

Notes on Current Topics.

Oleum Ricini for Neuralgia.

THE therapeutic measures recommended for the relief of neuralgia are many and various, the records, however, of undoubtedly successful treatment by drugs in serious cases are few and far between; it is therefore reasonable to exercise a certain degree of justifiable reserve in accepting the roseate accounts of continued series of cases of neuralgia being efficiently relieved by the internal administration of one to two ounces of castor oil daily before breakfast. The remedial value of the oil expressed from the seeds of *ricinus communis* in *tic douloureux* appears to have been first put forward in the German medical press, but it is from the records of Dr. Ochsner's surgical clinic at Rush Medical College that the most precise details are supplied in favour of the use of castor oil in the treatment of neuralgia, particularly of the fifth nerve. According to Dr. Ochsner's experience, out of a series of 13 consecutive neuralgia cases that attended for operation all were relieved or greatly improved by the use of castor oil. This brilliant record is not equalled by Dr. Moyer, who treated about fifteen cases of neuralgia in this manner. In one case it is reported that a "large" dose of castor oil at one o'clock had largely decreased the pain in an acute attack by four o'clock, and after three or four doses of the oil there was no return of the pain. In another consecutive series of a dozen cases where the routine treatment was the administration of castor oil, it is stated that great benefit was derived with the exception of two cases. It appears that it is not contended that castor oil is of use in neuralgia connected with migraine headaches. The continuous daily use of oleum ricini, as well known, results in a diminution of the cathartic tendency of the oil, and it is recommended to be taken by others than children in Bass ale or some beer that readily froths. A little ale should be poured out so that frothing occurs, then the oil is added, stirred, and can be drunk without any nausea. If the precaution be taken of washing the oil in water, its acidity and disagreeable taste are much lessened. There is good reason for the belief that much remains to be known concerning the unidentified substances present in castor oil, and although the enthusiastic support of this new method of treatment may be eventually found to rest on a basis wanting in some respects in thorough accuracy, still there has been good enough work done, and sufficient results obtained, for a fair and impartial trial to be accorded to this interesting departure.

Street Noises.

SPAIN is not generally deemed one of the countries that has advanced farthest in modern civilisation, and yet in one particular the Spaniards will be admitted, especially by the long-suffering Londoner, to lead the way and set an example to others most worthy to be followed, for Spain is the country where, from reports presented to the House of Lords, the barrel-organ nuisance has been altogether suppressed. The dwellers in towns and cities except in such a favoured place as Eastbourne, must, unfortunately in this free country, submit to the tyranny of unrestricted licence and chaos in the matter of street noises. It is hard to conceive why there should be a passive opposition to reasonable regulations being made to control those who emit hideous and discordant noises at all times of the day and night in the streets of large towns, but when it is remembered that these auditory disturbances are as objectionable as they are unnecessary it is still more difficult to explain away the apathy of the suffering citizens who tolerate in such a metropolis as London a multiplication of preventible noises practically constituting an invasion of the liberty of the subject. The Society for the Suppression of Street Nuisances is doing good work, but it lays itself open to friendly criticism when it infers that the louder a milk vendor shouts the more adulterated is his milk. Surely, too, the good cause the society has at heart will not be benefited by describing the paper boys of Smith and Son and Willings as "uncouth and sickly-looking." Is it not also slightly inconsequential to affirm that if a newspaper is not "with the Society" in their excellent crusade, therefore that paper panders to the gambling spirit of the age. The Society has the support and the active sympathy of all reasonable people, and with such assistance its just and sensible objects must in the end be gained; but exaggeration in the statement of any programme necessarily brings with it certain and appreciable delay in the full accomplishment of the ends desired.

Dermanyssus Avium.

IN an interesting address, entitled "Clinical Memories," delivered in London a few days since, Sir William Gairdner concluded by relating the details of a case which gave rise to some difficulty, before the correct diagnosis was arrived at by those immediately concerned. Sir William said that he received one day a letter from an experienced practitioner giving the details of what he described as a distressing case of a lady, who, in visiting the poor, had become infected with lice. The patient was naturally subjected to much bathing, and repeated changing into clean clothes and solutions of different kinds were freely applied, but all to no purpose. Her apparel was disinfected at a temperature above 300°, and yet the loathsome infection was not alleviated. The advice of skilled dermatologists was invoked, some of the "lice" in question produced for examination, and it was ultimately decided that the parasites were after all not pediculi. They certainly were not lice in the

ordinary sense of the word, and it was not till after considerable search that the experts found a parasite, *Dermanyssus avium*, which presented a certain resemblance to the specimens sent. A reply was therefore sent to the medical man suggesting that the "lice" might be derived from poultry, and it was subsequently ascertained that the lady was a great fancier of poultry and was in the habit of nursing favourite fowls in her lap, which accounted for the continuance of this peculiar disease.

A Flippant Board of Guardians.

THE York Board of Guardians appear to stand in need of a sharp lesson on the responsibilities attached to their position, judging from the report of a recent meeting that appeared a few days since in the *York Daily Herald*. It seems that a L.G.B. inspector visited the infirmary a short while ago, and in a subsequent report has condemned the sleeping accommodation for a portion of the female imbeciles. The chairman of the guardians so far forgot the dignity of his position as to say that Her Majesty's inspectors must be doing something, and as a rule what they said was capable of very liberal discount. He is also credited with the observation that it was a pity the officials mentioned could not stay at home at holiday times. A lady guardian made the fatal admission that three attendants could not keep the imbeciles tidy. Reading between the lines that last statement is a pregnant commentary in proof of the condemnation of the existing arrangements. The York guardians will do well forthwith to carry out the recommendations of the Local Government Board to provide new accommodation on modern principles for the imbeciles under their charge. York is the last place in the United Kingdom from whence we should expect to hear of a retrograde step in the treatment of the insane. It is to be hoped that the Local Government Board will brook no delay in carrying out orders by this flippant board of guardians.

A Mysterious Death and Inquest.

ON May 22nd Captain Frank Hercules Robinson, son of Lord Rosmead, was run over in the Strand and taken to Charing Cross Hospital, where he was examined by the House Surgeon. So far as can be ascertained he was kept under observation for about twenty minutes, when he was declared to be drunk. Accordingly, the police officer in attendance took him off to Bow Street, and placed him in a cell, where he was found a few hours later in an unconscious state. He was then removed to King's College Hospital, where he was discovered to be suffering from a compound fracture of the skull, and the diagnosis was verified at the subsequent post-mortem examination. The jury added a rider to their verdict, in which they stated their conviction that "the authorities of Charing Cross Hospital were grossly to blame." In view of the frequent obscurity of fracture of the skull, however, it is possible that the medical officer who saw the case may have a very good excuse for the unfortunate oversight. At the same time it would be more re-

assuring to the public who find the funds for the medical charities to learn whether the late Captain Robinson was sent away on the authority of an experienced person, or merely upon that of a student or a newly-qualified man. To decide the exact nature of many of the cases that come into the casualty wards of a hospital demands the utmost medical skill. If Charing Cross Hospital can show that such skill was applied in this distressing case it will do much to restore the confidence of the general public in the management of these important medical charities. We should like to know who attended the deceased, the date of his qualifications, and on what grounds he arrived at his diagnosis. Then, too, there is evidence of an abortive attempt to prevent the proceedings at the inquest becoming public, indeed they only leaked out through the ubiquitous and irrepressible curiosity of an evening paper. The danger of this conspiracy of silence was illustrated years ago in the case of the Bravo mystery, when a hushed-up inquest was reopened through the agency of the *Daily Telegraph*, and an instance of criminal poisoning brought to light. In most instances the coroner is no party to a very natural, but nevertheless ill-advised, attempt on the part of the relatives to check a publicity which cannot but be painful to their feelings, and in this particular instance we have no doubt that the coroner may be completely exonerated from any participation in the hushing-up process.

Degrees in Pharmacy.

FOR some years past an agitation has been in progress in the pharmaceutical world to obtain university recognition of the claims of pharmacy to be a science deserving of a titular stamp. Beyond the not unnatural desire of pharmacists to bear the university brand we fail to see any plausible ground for the claim. Pharmacy is a calling rather than a profession. It does not lend itself to academical distinction; and, so far as the sciences germane to pharmacy are concerned, it is within the power of any pharmacist under existing arrangements to obtain a degree if he will only put in the necessary labour. There are, on the other hand, grave objections to a purely pharmaceutical degree. First and foremost the possession of a degree entailing the right to the prefix "Doctor" would completely obliterate the distinction which, in a blurred and imperfect form, still exists in the minds of the public between pharmacists and medical practitioners, and would *pro tanto* facilitate the carrying on of illegitimate counter practice. The matter has not so far gone further in this country than the reiterated expression of a desire, but it may be hoped that the leaders of pharmacy will recognise the futility of the movement and the undesirability of its accomplishment.

The Friendly Societies and Wage Limits.

THE Annual Movable Committee of the Manchester Unity of Oddfellows met last week at Portsmouth. One of the officials introduced the subject of a wage limit for members of friendly societies, a principle which had been adopted by a

recent meeting of the medical profession at Manchester. To that wage limit the speaker asserted the friendly societies would never agree, a position that secured the unanimous support of his hearers. In other words, these worthy oddfellows assert that anyone who chooses to join their ranks, no matter whether his daily income be reckoned by shillings or by pounds, has a right to secure skilled medical attendance and physic by the yearly payment of a paltry subscription. The essence of the whole thing is that the service is rendered to persons who are not in the receipt of anything beyond ordinary artisan incomes. The wonder of it is that anyone who is comfortably provided with this world's goods can be mean enough to secure medical attendance in so mean a way. Yet any club doctor of any wide experience would have no difficulty in furnishing instances of persons with ample means throwing themselves upon the medical lists of the friendly societies. The latter bodies say they will engage their own medical officers. If that be the case the sooner we have an outspoken opinion of the General Medical Council upon the legality and honourable value of such contracts the better for the profession.

The Elections at the Royal College of Surgeons, Ireland

WE, last week, reported, very briefly, the result of the elections of President, Vice-President, and Council of the College. The figures attached to the names did not indicate as might appear the number of votes, nor the age of the candidates as might appear, but their respective attendances at the meetings of the outgoing Council. Mr. Myles was chosen as President, unopposed; and Mr. Ormsby as Vice-President, by a majority of 37 over Mr. Heuston, the competing candidate. Of the 19 outgoing councillors 16 were re-elected. The vacated seats were those of Mr. Myles to President, of Mr. Ormsby, chosen Vice-President; and of Mr. Fitzgibbon, who was not re-elected; and they were succeeded by Mr. C. B. Ball, Regius Professor of Surgery in the University of Dublin; Mr. Graves Stoker, Surgeon to the Whitworth Hospital, Drumcondra; and Mr. Conway Dwyer, of Jervis Street Hospital. There were other candidates—Mr. Woods, of the Richmond Hospital; Mr. Morrison, of Dundalk; Mr. Hillis—who did not secure seats. Since the election the Council has met to appoint the committees to carry on the business of the College, and there was no material change in the constitution of these committees, save in the appointment of Dr. Jacob as one of the representatives of the College on the conjoint Committee of Management of the Examinations and as Honorary Librarian, both of which positions had been vacated by Mr. Heuston. The resolutions of the College adopted at the annual general meeting have, of course, priority of all other Council business, and they will be considered at the next Council meeting when they shall have been reported by the Secretary of the College, Sir Charles Cameron. These resolutions are conversant with the questions of can-

vassing for votes, and with the unauthorised grant of a diploma.

Monogamy and Longevity.

IN a very original article from the fertile pen of Dr. Harry Campbell the hypothesis is put forward that monogamy tends to favour the increase in the race of all late-life diseases, cancer among others, and, incidentally, to shorten the vital span. Dr. Campbell proceeds on the assumption that there is a tendency for all organisms, vegetable as well as animal, to die soon after the cessation of reproductive life, a tendency which he believes applies equally to man. Obviously, however, it can hardly apply to woman, in whom the reproductive period is strictly limited, yet whose span of life on the whole exceeds that of man. It is difficult to assign any well-defined limit to the reproductive period in man. A flippant Frenchman has remarked that while a man may have a child if he marries at sixty, he is sure to have one if he marries at seventy or later. The author points out that monogamy, by restricting one man to one woman, virtually reduces the reproductive period of the man to that of woman; but here again this result is, we imagine, more apparent than real, since reproduction is a two-sided function and reproductive impotence on the one hand does not entail a corresponding, but only a nominal, impotence on the other. Dr. Campbell's contention is apparently that this artificial curtailment of the reproductive period in man exposes him to greater risk of late-life diseases, but to prove this hypothesis it would be necessary to show that those whose sexual functions decline early in life are more prone thereto and in any case that women, whose period of exposure to these late-life diseases is so much longer, suffer in greater proportion from this class of malady, an assumption which it might possibly not be difficult to substantiate. Even if we admit that monogamy entails some such risk, Dr. Campbell is not prepared with a ready means of averting the wrath to come. He recognises that polygamy is a sociological impossibility, and he is fain to fall back on individual voluntary elimination as a means of improving the racial standard. From this point of view the prospect, we fear, is not very encouraging.

Newquay and the Notification of Measles

All who know that most charming and fashionable of Cornish sea-side places, Newquay, will watch with interest the action of the district with regard to a question that has far more than a merely local bearing. An isolation hospital has been built in the town, and it has been proposed to admit typhoid fever and measles to that institution. Then came the knotty point as to the notification of measles, which is certain to involve the ratepayers in a good deal of expense. That measles should be treated in the same way as other ordinary infectious diseases we entertain no doubt whatever. It is a most infectious and universal malady, of a deadly nature when not properly treated, but under good conditions trivial and harmless. The

chief difficulties in the way of prevention appear to be the infectiveness of measles in the earliest stages, and the difficulty of providing sufficient hospital accommodation. There seems to have been a sharp epidemic of the disease recently in Newquay, which is clearly interested in keeping infectious diseases as far as possible outside its walls. The question of notification has been shelved for the present, but it is to be hoped that the local authorities, having taken the advanced step of admitting measles to their infectious hospital, will not detract from the value of their example by refusing to pay for notifications. Newquay has put to shame many old-established watering-places, in which the modern methods of preventive medicine are still unknown.

The Appointment of Solicitor to the General Medical Council.

THE vacancy caused by the resignation of Mr. Farrer of his office as standing Solicitor to the General Medical Council has been filled by the election of Mr. William Howard Winterbotham to the post. This gentleman is a member of the firm of Waterhouse, Winterbotham, Harrison, and Harper, of New Court, Lincoln's Inn, and has since 1895 held the position of Official Solicitor to the Court of Appeal, Royal Courts of Justice. We have reason to believe that the General Medical Council have decided to call in the assistance of a second lawyer for the purpose of carrying out legal work in connection with police-court cases and other actions at law. With the recent experience in the Alabone case still fresh in their minds, the General Medical Council could not well have decided otherwise, and they have done wisely in determining to adopt an alteration in the system hitherto followed in the conduct of the legal business of the Council.

Women Who Insure.

IN the course of one of his lectures, Dr. Poore lately discussed the question of women insuring their lives, and drew attention to the remarkable fact that while the expectation of life is, on the average, greater in women than in men, among women who insure it is less. The fact is quite capable of proof that the insuring woman, age for age, is a greater risk to a life office than the insuring man. As a rule a woman does not trouble about insuring her life and as a matter of fact insurance among women is less common than among men. The rarity of women insuring is because the provision for the family is a matter which usually rests with a man. The woman who insures very often has to bear the battle of life like a man and cannot stand up against it so well; further, the woman who insures is often a person who has got into debt, and women of that kind are very "bad lives."

Professional Risks.

AN action was recently tried in the Lord Chief Justice's Court in which the plaintiff, a fireman formerly employed by the London County Council, sought to recover damages for having had to resign

his post by reason of the medical officer having certified him to be suffering from venereal disease. Without waiting for the completion of the medical evidence the jury returned a verdict in favour of the defendant. It is satisfactory to add that the Council have decided to pay the defendant's bill of costs, which amounted to a considerable sum. This is as it should be, seeing that the liability was incurred in the discharge of his duty as medical adviser to the Council.

Bleeding in the Treatment of Uræmia.

ALTHOUGH it is not altogether easy to afford a plausible scientific explanation of the value of bleeding in certain toxic states, such as uræmia, diabetic coma, and eclampsia, experience seems to show very clearly that free bleeding is not unfrequently followed by marked relief of the most urgent symptoms. The ostensible object of the bleeding is to remove from the circulation certain noxious substances which have accumulated in the blood as the result of imperfect elimination, or excessive production, but experimental investigation does not bear out this hypothesis. The effect is said to be enhanced if the bleeding is followed by extensive subcutaneous saline transfusion.

The Centenary of the Royal College of Surgeons of England.

It is proposed to celebrate the centenary of the foundation charter of the Royal College of Surgeons of England by a *conversazione* at the College on Wednesday, July 25th, to be followed on Thursday, July 26th, by the inaugural meeting in the theatre of the University of London, Burlington Gardens, when an address will be delivered by the President, and honorary fellowships will be conferred on the elect. On Thursday evening a festival dinner will be given in the hall of Lincoln's Inn at 8 p.m., at which a limited number of seats will be reserved for Fellows and Members of the College, application for which should be made forthwith to the Secretary. The price has been fixed at two guineas, which will include admission to the *conversazione* and inaugural meeting.

School Children Statistics.

DR. CHRISTOPHER, of Chicago, brought before the American Society of Pædiatrics some interesting statistics bearing on the physical and intellectual development of school children. He finds that, from a muscular point of view, the girls are in advance of the boys up to the age of 14. At this age girls attain their maximum muscular development whereas boys go on developing until the age of 20, and at the latter age the girls are inferior to the young men to the extent, approximately, of 50 per cent. Dr. Christopher holds that there is a close and fairly constant relationship between physical development and intellectual powers and a condition of physical inferiority is almost invariably associated with corresponding intellectual inferiority. Dr. MacDonald, of Washington, who has made some twelve thousand

observations on school children, confirms these deductions, and adds the further curious fact that children born in summer are generally stronger and more intelligent than those born during the winter months. Another point investigated by Dr. Christopher was the influence of the holidays on the weight of the children, but, as might be expected, no very definite results were obtained owing to the very variable influence of environment.

Influenza Merging into Typhoid Fever.

DR. POTAIN, of Paris, recently called the attention of the Academy of Medicine to the comparative frequency with which persons suffering from influenza develop typhoid fever. The transformation, he states, usually takes place in the course of the attack or during convalescence. Just at the time when recovery from the attack of influenza appears to be imminent the temperature rises, the patient complains of intolerable headache, the spleen becomes enlarged, and palpation of the right iliac fossa reveals the characteristic gurgling. This post-influenzal typhoid usually runs a mild course, and the prognosis is not aggravated by the pre-existing influenzal infection. Dr. Potain insists on the fact that the initial attack was really influenzal, as evidenced by the well-known symptomatology; moreover, the appearance of the rose-coloured red spots from the fifteenth to the thirtieth day after the initial symptoms proves that the patients were not originally suffering from typhoid fever.

THE annual dinner of the Brussels Medical Graduates Association will take place at the Café Royal, Regent Street, on Tuesday, July 3rd.

THE Guardians of Lincoln appear to have had some difficulty in finding a Medical Officer, but Dr. J. G. Dunlop, of Glasgow, has assisted them out of the dilemma by accepting the post, one of the guardians opining that he (Dr. Dunlop) was "the right sort of chap." Dr. Dunlop is to receive the munificent salary of £70 a year, which is less than half the amount accorded to the relieving officer who has admittedly "not half nor quarter the work." We trust he may find the post to his liking.

PERSONAL.

MR. OSBORN, chief surgeon of the St. John Ambulance Brigade in South Africa is reported to be on the point of return to England.

MR. CHRISTOPHER HEATH has been elected president of the Society for the Relief of Widows and Orphans of Medical Men.

MR. THOMAS MYLES, President of the Royal College of Surgeons in Ireland, has intimated to the Town Clerk of Limerick, that he proposes to attend the meeting of the Town Council on Saturday, the 16th inst., for the purpose of receiving the freedom of that city. The members of the medical profession in the city and county will also present Mr. Myles with an address of congratulation on his appointment to the Presidency of the College.

CONTREREVILLE is becoming quite a haunt for royalties. Our Foreign Correspondent writes us that the Shah of Persia is the latest arrival at this health resort.

MR. R. MARCUS GUNN, F.R.C.S., will deliver the annual "Bowman Lecture" before the Ophthalmological Society of Great Britain on Friday evening next, the subject being "Visual Sensations."

THE late Baron de Rothschild, of Paris, who, we may remark *en passant*, was a subscriber to this journal, has left a sum of ten millions of francs for the foundation and maintenance of a hospital for eye diseases in Paris.

DR. G. F. MCCLEARY has been appointed, subject to the approval of the City Council, junior assistant to the Medical Officer of Health for Manchester, in connection with the notification of phthisis, at a salary of £200 per annum.

DR. S. POZZI, the eminent French surgeon, and Senator, has just had to submit to the ordeal of a duel, he having been provoked, on political grounds, by a Dr. Devillers, of whom, from a scientific point of view, we know nothing. We are pleased to state that no more serious result occurred to Dr. Pozzi than a slight wound of the wrist.

AT the meeting of the Council of the Royal College of Surgeons in Ireland on Thursday last, Dr. Archibald Hamilton Jacob, a member of the Council, was unanimously chosen to succeed Mr. Houston (who has ceased to be a member) as honorary librarian to the College, and as one of the three representatives of the College on the Committee of Management for the conjoint examinations with the College of Physicians.

SIR WILLIAM GAIRDNER, on the occasion of his resigning the Professorship of Physic in the University of Glasgow, is to be entertained by his friends at a dinner on the 19th inst. Tickets can be obtained of Mr. Macle-hose, 61 St. Vincent St, Glasgow.

MR. ARTHUR CHANCE, Surgeon to the Mater Misericordiae Hospital, Dublin, has issued his cards to the Fellows of the Royal College of Surgeons in Ireland intimating his intention to seek the Vice-Presidency of the College in the year 1902.

AS an authenticated instance of longevity incidentally connected with the medical profession, we may mention the 107th birthday of Mrs. Hanbury, of Richmond, on Saturday last. Her son, Mr. Cornelius Hanbury (head of the firm of Allen and Hanburys), also celebrated his golden wedding last week, to whom we offer our salutations.

DR. J. FARRELL EASMON, late Chief Medical Officer, and a leading authority on tropical diseases, died on Saturday last of pneumonia, at Cape Coast Castle. The general health both of Europeans and natives is very bad at the present time. Dr. S. H. R. de Groot, who is in charge of the base hospital, remains the only medical man in the place.

PROFESSOR CHIENE, Professor Ward, Mr. Golding Bird, and Mr. Bernard Pitts have been appointed

Examiners in Surgery; Drs. Cullingworth and Free-land Barbour, Examiners in Midwifery; Drs. Isambard Owen, Lees, Donald McAlister, and Greenfield, Examiners in Medicine in the University of Cambridge.

WE are pleased to learn that Dr. J. J. Cranny of Jervis Street Hospital, Dublin, whose serious illness we recorded three weeks since, has quite recovered and has resumed his official duties. Dr. Henry Colpoys Tweedy, physician to Dr. Stevens's Hospital, is, also, we are pleased to report, convalescent and may be expected to return to work shortly.

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

ELECTION OF FELLOWS AT THE ROYAL COLLEGE OF PHYSICIANS, LONDON.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—An Indignant Fellow "seems to think that the Fellowship of the Royal College of Physicians is given for no other reason than *honoris causa*. If the College of Physicians obtained its charter for this purpose, it would be another thing; but it was not for the benefit of its Fellows that the Charter of Incorporation was granted by Henry VIII. to the President, &c. The "reasons of incorporating" are stated on p. 5 of the "Charter, By-Laws," &c., as being "to check men who profess physic and other from pure avarice than in good faith, to the damage of credulous people."

In that charter there is no suggestion of the F.R.C.P. being given *honoris causa*. The way in which our societies are utilised by the titles they bestow to attract public notice and for the benefit of the individual, is a subject that deserves attention.

I am, Sir, yours truly,

Kensington, June 7th.

F.R.C.P.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The letter in your issue of June 6th from "An Indignant Fellow" leads one to imagine that indignation has somewhat swamped his less emotional faculties. Although I do not live in London, I may say that with little effort it is possible to recall many instances that will more than satisfy the challenge thrown out by your correspondent.

No. I.—Dr. T. J. MacLagan has been a Member of the College of Physicians since 1882. He took the M.D. of Edinburgh University in 1860, and is Physician in Ordinary to their Royal Highnesses Prince and Princess Christian of Schleswig-Holstein. As the discoverer of the action of salicin in rheumatism he has conferred a lasting benefit upon the whole of mankind, and has achieved one of the most brilliant advances in practical medicine made during the present or any other century.

No. II.—Dr. C. D. F. Phillips, who enjoys the unique distinction of possessing the LL.D., *honoris causa*, both of Edinburgh and of Aberdeen Universities. He has written a well-known book in three volumes on *materia medica*, and has been an Examiner in Edinburgh. He took the M.R.C.P. in 1877.

No. III.—Surgeon-General J. A. Marston, C.B., formerly head of the Statistical Branch, Medical Department, War Office; Delegate of the British Government, International Medical Congress, at Washington, 1887; with other distinguished posts. He has made many valuable contributions to the study of tropical diseases. He became M.R.C.P. in 1887.

Many more cases might be cited, and if the indignation of your correspondent be not abated by the foregoing I may venture at a later date once more to seek the hospitality of your columns. The Provinces afford many examples where the Fellowship of the Royal

College of Physicians of London has been both "unduly withheld and improperly bestowed."

I am, Sir, yours truly,

AN INDIGNANT MEMBER.

Somerset, June 8th, 1900.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Has your correspondent, "An Indignant Fellow," pursued his researches into our Indian Empire? If so, perhaps he will tell me why the Fellowship has not been bestowed upon Anghorechunder Chattapadhya, of Calcutta, who obtained his membership in 1882, and whose name must be familiar to most of your readers.

I am, Sir, yours truly,

AN INDIGNANT PARSEE.

The Temple, London, E.C., June 8th, 1900.

CAMBRIDGE APPOINTMENTS ASSOCIATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I am rather surprised that Mr. Archbold does not avail himself of the opportunity offered by your journal to give publicity to the advantages of medical education provided in the University of Cambridge for those preparing for general practice. If Mr. Archbold is satisfied that the "needs of the coming general practitioner are quite as carefully looked to as those of the specialist," I should be quite prepared to find that they are not looked to at all; for no one would venture to say that any attempt is made at Cambridge to prepare for specialism.

If Mr. Archbold thinks that he satisfies me by saying that Cambridge prepares for general practice as much as it does for specialism, I should certainly not advise any of my friends to send a son there. What is done at Cambridge in medical education ought to be widely known.

I am, Sir, yours truly,

June 8th, 1900.

INQUIRER.

THE LICENTIATESHIP OF THE SOCIETY OF APOTHECARIES.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—After reading your editorial anent the Society of Apothecaries, I could not but feel how much such discussions filtering to the lay mind may injure the position and practices of those who are licentiates in medicine and surgery of that body. People seem to have an idea that an apothecary is a kind of druggist only. May I suggest the use by all of the non-controversial term "apothecary-surgeon," especially now that surgery is an essential part of their final examination.

I am, Sir, yours truly,

Bradford, June 8th.

P. L.

THE ROYAL COLLEGE OF SURGEONS, IRELAND.

THOMAS MYLES, M.D., v. HENRY FITZGIBBON, M.D.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I shall be obliged if you will publish in your next issue the annexed report from the Dublin papers of this date of the termination of this action. The action was brought by Mr. Myles, M.D., Vice-President of the Royal College of Surgeons, Ireland, against Mr. Fitzgibbon, M.D., a Fellow of the same college, for libel and for an injunction to restrain further publication thereof. One of the terms of the consent was that the result of the action should be published at the expense of Mr. Fitzgibbon in, among other papers, the MEDICAL PRESS AND CIRCULAR.

I am, Sir, yours truly,

JOHN WALKER,

Solicitor for the Plaintiff.

25, Eustace Street, Dublin, June 2nd, 1900.

[COPY REPORT.]

COLLEGE OF SURGEONS.

DR. MYLES' ACTION.

Yesterday, in the Queen's Bench Division (Court No. 2), before Mr. Justice Gibson, Mr. Justice Madden, and Mr. Justice Kenny, the case of "Myles v. Fitzgibbon" was mentioned for the purpose of settlement.

The Solicitor-General, with whom were Mr. T. L. O'Shaughnessy, Q.C., and Mr. William Gibson (instructed by Mr. John Walker) applied on behalf of the plaintiff, Dr. Thomas Myles, to receive a consent and make it a rule of court. Counsel said it was a very fit termination of an action which would have been a very serious one indeed if it had gone on. The defendant was Dr. Henry Fitzgibbon. The action was for libel contained in circulars and prints published by Dr. Fitzgibbon by being sent to each member of the Royal College of Surgeons in Ireland. The circulars reflected in very strong terms, indeed, on Dr. Myles, and the allegations contained in them endeavoured to show that he was unfit to be elected President of the College, for which he was a candidate. Dr. Myles, on the circulars being brought under his notice, at once issued a writ, and applied for, and was granted, an interim injunction restraining Dr. Fitzgibbon from publishing them. The order was served on the defendant, and had the effect that the action was settled on the terms which counsel would state. The defendant wrote the following letter to the plaintiff:—

"I regret the publication and circulation of the two circulars, and the reprints from the *Evening Telegraph* newspaper which I sent to the Fellows of the Royal College of Surgeons, Ireland, in connection with the election to the office of President. I admit there was no justification whatever for associating you with the names or the organisations mentioned or referred to in the said circulars and prints, and I unreservedly withdraw all suggestions and imputations against you therein contained, and I apologise therefor.

"I have also this day withdrawn from the candidature for the Presidency of the College.

"I admit that my action left you no option but to commence legal proceedings, and to take the other steps you did to put the true facts before the Fellows of the College and the public, and I undertake to indemnify you against all costs and expenses of every kind which you have been put to since the issue of my circulars, including the cost of publication in such papers as you select, of this apology, and the making of a consent to stay your action on the terms contained herein a rule of court."

Continuing, counsel said a formal consent was signed by the parties and their solicitors in the following terms:—

"The defendant having apologised to the plaintiff, it is hereby consented and agreed by and between the parties to this action, testified by their respective signatures hereto, and the signatures of their respective solicitors, that this action and all proceedings therein be stayed upon the terms following, viz.:—That the defendant do indemnify and pay to the plaintiff all expenditure and costs (such costs to be paid as between solicitor and client), of whatsoever kind which the plaintiff in his discretion or for his guidance has incurred since the publication of defendant's circulars and prints, or which he shall incur in refuting same, including the costs of the injunction obtained by the plaintiff in this action, and the costs of making this consent a rule of court, as hereinafter provided, and the costs and expenses of the publication of this apology and the result of the action, in such newspapers and journals as plaintiff may select. And it is further consented and agreed that this consent shall be made a rule of court, the application for that purpose to be made in open court by counsel on behalf of the plaintiff."

The consent was made a rule of court.

THE FISH AND MOSQUITO THEORIES OF LEPROSY.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In your review of "Twentieth Century Practice," Vol. XVIII., Syphilis and Leprosy (May 2nd, 1900), you say:—"The author (Dr. Morrow) very summarily disposes of the preposterous 'fish theory' of the origin of leprosy, so stoutly advocated—strangely enough—by no less eminent a clinician than Mr. Jonathan Hutchinson. The inhabitants of Kurdistan and Kashmere are mentioned where leprosy is found,

although fish diet is never used. The Kaffirs are, we believe, a prominent example of the existence of leprosy among a people to whom the rules of caste forbid the use of fish as a food."

Let me say that Neumann, of Vienna, in his observations, gave great importance to the question of the fish diet, and claimed that it was "shown that the consumption of fish in Bosnia is a minimum. Even the inhabitants of those parts which abound in fish make little or no use of this aliment; this is still more true for the inhabitants of the districts which are situated farther from the course of the streams. The questions addressed on the subject to the lepers elicited the answer that the patients had never, or only exceptionally, eaten fish. Only in three cases abundant fish diet was shown. From these quite reliable observations it appears that for leprosy in Bosnia the influence of fish diet is in no relation at all."

Neumann goes on—"In the work of Golo, which is quoted by Ashmead, all fish and aquatic animals which are reported to produce leprosy when used as aliments, are enumerated. The fact is also pointed out that the Japanese leper villages lie on the coast, that the garbage and leprosy products get into the water and are there received by the fish, so that the latter are to be considered as bearers of leprosy. Ashmead hereby ascribes an influence to the fish diet, while A. Crane contradicts him directly in pointing out that in the first half of this century, when in Hawaii, fish formed almost the total of the popular diet, leprosy was rare, while now, when the fish diet is much reduced, the dimensions of leprosy are enormous," and further, Jonathan Hutchinson ("Archives of Surgery") says: "The theory that mosquitoes are a means of contagion in leprosy has had its advocates. It is, however, I think conclusively negated by the fact that of the European immigrants into leprosy districts hardly any contract the disease."

Will you permit me, Mr. Editor, to inform you that I am a firm believer in the *fish and mosquito theory* of contagiousness of leprosy. That the mosquitoes act as hosts of the spore of leprosy to communicating germs to the fish, especially the carp, which feeds on mosquitoes, and that the fish of Japan, in their turn, being eaten raw, even alive, in my opinion communicated in many instances, but not in all, the disease to man. In this way they act as intermediary hosts in the propagation of leprosy. This is not Jonathan Hutchinson's theory. He believes in fish alimentation as a cause of leprosy. If my theory is not true, how can we explain that in Japan, in the most notoriously malarial districts, like Myasaké, Kamamolo, Kagoshama, Awamori, &c., are to be found the most lepers. How would Jonathan Hutchinson explain that? Because in leper asylums it is not a European doctor or Sister of Mercy who becomes contaminated, is that a reason why mosquitoes may not be carriers of infection given certain other factors, still unknown to us? Because the negro transplanted to Panama, when the railroad was building across that isthmus, did not die of malarial fever, as his white brother did, was that proof that mosquitoes were not carriers of malaria? What Neumann and Crane say as to the prevalence of leprosy in places where fish is not abundantly eaten, proves nothing against the theory of fish as intermediary hosts of infection. Until the fish is itself infected, and until it is eaten raw, I do not think that cooked fish diet can be a source of contagion.

I merely add that I never was a believer in Jonathan Hutchinson's *alimentation* theory.

I am, Sir, yours truly,

ALBERT S. ASHMEAD, M.D.

New York, May 14th, 1900.

THE RONTGEN RAYS IN MEDICAL AND SURGICAL WORK.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—I have read with great interest Mr. Macintyre's paper in your issue of June 6th, and am especially pleased to find that his experience has led him to speak so favourably of the electrolytic interrupter. I have been using various forms of electrolytic interrupter for

X-ray and other work for some time, and from my own experience I have come to the conclusion that, in spite of the fact that they are rather hard upon the tubes, the results are extremely satisfactory, and compare very favourably with any form of mechanical break.

The one which I prefer is that of Campbell Swinton's, where the pointed glass rod fits in the hole in the glass tube, but there is the great fault that the tube is very liable to break while the current is passing, with the result, of course, of melting the fuse and stopping the work. I should be glad to know if Mr. Macintyre has found any way of getting over the difficulty, as if it was not for this the power of regulating the current which the interrupter gives would make it a most useful one. With regard to what Mr. Macintyre says about the relative brilliancy of the fluorescence of calcium tungstate, I have noticed the curious fact that this depends largely on the dampness or dryness of the screen and the atmosphere at the time.

I am, Sir, yours truly,

RICHARD J. COWEN.

25, Clarges Street, Mayfair, June 7th, 1900.

MIDWIVES LEGISLATION—A PROTEST.

We have been requested to give publicity to the following letters:—

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—With the permission of the chairman of the Beckenham and Penge Medical Society, I forward the following correspondence for publication. Trusting you will kindly find room for it,

I am, Sir, yours truly,

J. G. GLOVER.

25, Highbury Place, N.

DEAR MR. GLOVER,—At a recent meeting of the Beckenham and Penge Medical Society Dr. Sturges, who was present as one of the delegates of the society at the meeting held at the Cannon-street Hotel to protest against the Midwives Bill at present before Parliament, reported what had taken place at that meeting, and referred in terms of strong disapproval to the general management of the meeting, and in particular to the motion which was brought by Dr. Lorrimer Hart with reference to yourself just before the close of the meeting, when only a few gentlemen were present.

This Society assisted the Corporate and Medical Reform Association and other societies in organising the Cannon Street meeting, and our delegates went prepared to submit some very carefully-considered alterations in the Midwives Bill, which they hoped might render it a useful measure, and one which would safeguard the public and be acceptable to the general practitioner.

In consequence of the manner in which the meeting was conducted the Beckenham and Penge Medical Society have under consideration the desirability of severing their connection with the Corporate and Medical Reform Association, and this they will doubtless do at their next general meeting. Meanwhile, I am directed to express to you the deep regret we all feel at the action taken at the meeting with regard to yourself, and to assure you of our continued confidence and esteem.

I remain, Dear Dr. Glover,

Yours very truly,

F. ALEX. BARTON, Hon. Sec.

Beckenham and Penge Medical Society, Oakwood Avenue, Beckenham, June 6th, 1900.

DEAR MR. BARTON,—I am much obliged to you and your society for the expression of your views touching the Cannon Street Hotel meeting and its action towards myself. It is impossible that we should agree on all details of a question so complicated as that of midwives. But I believe the agreement is deeper than is thought, and it will be much promoted by generously construing each others views of the best way of promoting the end we all aim at—the saving of the life of poor lying-in women and securing for all serious midwifery the advan-

tage of medical attendance. Kindly convey to your society my best thanks, and believe me,

Yours very truly,

J. G. GLOVER.

25, Highbury Place, June 8th, 1900.

F. Alex. Barton, Esq., B.A., L.R.C.P.Lond., &c.

Obituary.

DR. JAMES GIBBS BLAKE, OF BIRMINGHAM.

A PROMINENT personality will be missed from Birmingham medical circles. Dr. Blake had been suffering for some time from a functional affection of the heart, for which he sought the advice of Dr. Schott, at Nauheim, in the middle of May. There he suddenly developed pneumonia, and passed away on Sunday, the 27th ult.

Dr. Blake was born at Taunton in the year 1832, and was educated at one of the well-known colleges there. He was the son of Dr. James Dore Blake, who enjoyed an extensive practice, giving to the medical profession no less than four sons.

Dr. Gibbs Blake matriculated from Taunton, going up from his school as winner of the Longridge Scholarship to take his B.A. degree. He entered University College for his medical course, in which he greatly distinguished himself, going up with the unusually brilliant group including Sidney Ringer and Henry Maudsley. Blake took senior honours in botany, chemistry, materia medica, physiology, surgery, medicine, pathology, midwifery, and forensic medicine. He took also the Fellowes Gold Medal and an exhibition of £100 in clinical medicine, and, in addition, double honours in anatomy.

There is at University College a somewhat unfair custom of letting senior students compete with junior men. In many cases Blake took honours from men who had been working much longer than he.

He took his first M.B. degree in 1854, being at the head of his competitors in anatomy and botany, and securing two gold medals. He was also placed in the honours list in materia medica and pharmaceutical chemistry, and in 1856 he won the gold medal in medicine and honours in surgery. In the following year he completed his brilliant University career by obtaining the M.D. degree, and being elected a member for life of the governing body of the University. In the meantime he had been assistant medical officer at the Essex County Hospital. After acting as private secretary to Lord Mount Edgcumbe, as well as resident medical officer to the household for a short time, Dr. Blake went to Birmingham at the end of 1859, and began practice on January 1, 1860, having succeeded to the *clientèle* of Mr. Charles Parsons.

Dr. Blake and Mr. G. J. Jackson were the original trustees of Mason College, and on the death of Sir Josiah Mason, in 1881, Dr. Blake was elected his successor in the office of "bailiff."

Dr. Blake was one of the original founders of the Birmingham Graduates' Club, and was subsequently its president for a year. He was a man of attractive personality, genial, tactful, and conciliatory, and was greatly esteemed and beloved by a very large circle of friends and patients; a man of many accomplishments, a clever turner of wood and ivory. One of the writer's earliest memories of him was seeing him not only turn a set of billiard balls, but actually make the needful tools for the purpose. He was a gifted artist, a sound classical scholar, an excellent linguist, speaking French, German, and Italian. Though he did the really laborious part of constructing the Science College, he so effaced himself that outside Birmingham his name is scarcely ever associated with it. A medical friend who had known him for many years writes thus:—"How invaluable his experience would have been in constructing the new University of Birmingham!" Dr. Blake leaves a widow to mourn his loss, and one son, the Rev. J. E. Huxley Blake, the Vicar of Wilnecote.

THOMAS FITZPATRICK, M.D., M.A.DUB., M.D.
CANTAB, M.R.C.P.LOND.

WE regret to record the death of Dr. Thomas Fitzpatrick, of 30, Sussex Gardens, Hyde Park, W. Dr. Fitzpatrick was a distinguished graduate of Dublin University, obtaining his M.D. degree in 1862, and his M.A. in 1864. He was admitted M.D. of Cambridge in 1867, and elected M.R.C.P. of London in 1868. In 1856—the same year in which he was awarded the silver medal of the Pathological Society of Dublin for his work on "Chronic Diseases of the Liver," he indicated his future success in his profession by passing, at a competitive examination, for the post of assistant surgeon in the service of the H.I.E.C. His health, however, soon broke down, and after practising for some years in Ireland he settled to private practice in London. He married, in 1865, Agnes Letitia, youngest daughter of the late William Robinson, LL.D., of Tottenham, Middlesex, of the Inner Temple, Barrister-at-Law, J.P., and Deputy-Lieutenant of the County. He became Fellow of the Royal Medical and Chirurgical Society, and served as a Member of Council in 1894-1895; he was also a Member of the Clinical Society. Dr. Fitzpatrick was, however, far more than a talented physician, he was a *savant* in its highest sense, and a linguist of rare ability, conversing in Italian, German and French almost as fluently as in his own language, while his attainments as a classical scholar were far above the average. Moreover, he could read modern Greek with as much ease and pleasure as English. He possessed to a remarkable extent the facility, so essential to members of the profession, of winning the confidence and attachment of his patients, as well as the love and esteem of countless private friends. This power of attraction was due, perhaps, as much to his personal qualities, as to his unerring skill and treatment. Unselfish almost to a fault, his thoughtfulness for everyone, and his generosity and kindness to all who required help were proverbial, and it may truly be said of him that his right hand never knew what his left hand did. His two books, "An Autumn Cruise in the *Ægean*: or, Notes of a Voyage in a Sailing Yacht," and "A Transatlantic Holiday," proved him the owner of a facile and graceful pen. He was a brilliant conversationalist and a *raconteur* with an absolutely wonderful memory for reciting either prose or poetry. All knew him as a man of varied attainments, a steadfast and true friend, and a devoted husband for 35 years. The Irish capital's university has lost in him a distinguished son.

MR. HENRY PEACOCK, F.R.C.S.

THE death is announced of Mr. Henry Peacock F.R.C.S., M.R.C.P., of Bath. Mr. Peacock, who was 87 years of age, commenced his professional career in the Navy, where he saw a good deal of service in the forties and he was subsequently appointed Medical Officer to the Dockyard at Chatham, a post which he filled for nearly twenty years. On his retirement in 1862 he commenced practice in Ludbrook, Gloucestershire, and was appointed assistant-physician to the Gloucester General Infirmary, and to the Gloucester Provident Dispensary.

Analytical Records.

SPANISH BRANDY.

We have received for analysis a sample of brandy prepared by Messrs. Wilson and Valdespino, Limited, Jerez, Spain. The analytical examination of this brand of brandy gave the following figures:

Specific gravity at 60 degs. F. ...	9233 per cent.
Alcohol, calculated as proof spirit ...	98.26 "
" calculated by weight ...	48.27 "
" calculated by volume ...	56.07 "
Extractives ...	0.36 "
Mineral matter ...	0.009 "
Total acidity, calculated as acetic acid ...	0.064 "
Volatile acids " " " " " " " "	0.038 "
Fixed acids " " tartaric " " " "	0.031 "
Ethers, expressed as acetic ether ...	0.042 "

This brandy has the fine bouquet and flavour of a matured brandy in contradistinction to the artificial brandies prepared from crude spirit by the addition of flavouring essences. It is well-known that much of the "brandy" on the English market at the present time is spurious and is not obtained, as all brandies should be, by the distillation of wine. Recently published statistics show that although the land under cultivation for the production of wine in the south of France has decreased by about four-fifths since the year 1875, with a consequent fall in the quantity of brandy produced, yet the amount of brandy consumed in France and exported thence has enormously increased. These facts need no comment. The sample of brandy under consideration is distilled in Spain. The rich quality of wines made in that country is well known, and as a result the manufacturers of brandy should be able to produce a spirit comparing favourably with those manufactured in France.

The result of our examination has confirmed us in this view for the composition, as shown by our analysis, is equal to, and even surpasses, some of the high-class brandies produced in France. For medicinal purposes it is highly important to secure a reliable, unsophisticated spirit, and we are pleased, therefore, to be able to place this brandy on the list of those that may be safely prescribed by the medical profession. A good deal of it has been used at the base hospitals in South Africa, and good reports of its value have reached us from the medical officers in charge. Its taste is somewhat different from that of French brandy, just as French wines are distinct in flavour from Spanish wines. This fact, however, does not militate against its dietetic value, nor does it affect the stimulating properties for which brandy is employed in medicine.

KOLA-ASTIER.

WE have received from Messrs. Wilcox and Co., of 40, Haymarket, a sample of "Kola-Astier," a granulated preparation of the Kola nut. It is a very palatable product, presenting the characteristic alkaloids of the nut in a soluble form. On analysis a considerable quantity of well-crystallised alkaloid was obtained. The stimulating property of these alkaloids is well-known, and the "Kola-Astier" appears to be an elegant and trustworthy form in which to administer them. It is put up in packets of convenient size to be carried by tourists, cyclists, and others addicted to athletic pursuits who are likely to appreciate the extra energy and resistance to fatigue which Kola nut is reputed to engender. In the preparation of Kola-Astier, the vegetable framework of the nut is eliminated and its place taken by sugar, the active parenchyma being triturated therewith and granulated.

Literature.

SYMES' BACTERIOLOGY OF EVERYDAY PRACTICE. (a)

THERE is much to be said in favour of treating certain subjects in monograph form, and this is peculiarly true of such subjects as practical bacteriology, the directions given in the ordinary text-book being, as a rule, too vague to serve as a guide to the tyro in this department of observation.

Bacteriology is no longer the monopoly of specialists working in specially-fitted laboratories. It has become the handmaid of the modern practitioner, who is thus enabled to confirm his diagnosis, and to place it on a sound scientific basis. At present, it is true, the practitioner does not aspire to stray beyond tolerably narrow and well-defined limits, and this eminently practical little monograph deals only with researches well within the reach of the busy but conscientious observer.

The general plan of the work is (1) to point out in

what cases bacteriological examination may help in clinical diagnosis; (2) to describe methods of securing and identifying microscopic specimens such as the student and practitioner may themselves prepare; and (3) to give directions for taking cultures and for preserving tissues to be sent to the laboratory. The author has, however, added, in respect of many of the diseases under consideration, brief notes on appropriate preventive measures and the general principles of treatment.

The first chapter gives general directions for the preparation of staining solutions and the *modus operandi*. These are simple enough, at any rate in appearance, though rapidity and precision of execution can only be acquired by practice. The author then describes the methods of examining blood, pus, &c., for the discovery of parasites and micro-organisms of the commoner kinds, and points out the characters by which they can respectively be identified. The serum diagnosis of typhoid is discussed and its importance insisted upon. Lastly, there is a short chapter on the microscope and its use.

We can cordially recommend this little work as a sufficiently comprehensive and trustworthy guide to elementary bacteriology for purposes of clinical diagnosis.

Medical News.

Liebig's Extract of Meat Company.

JUDGING from the report presented at the annual meeting on Thursday last the past year of this Company, whose product is so intimately connected with the work of the medical profession, has been a good one in every respect, and the shareholders are to be congratulated on the result. Notwithstanding competition the sales keep on increasing, and exceptionally large shipments were made to the South African Field Force, and grants in kind had been given to the Red Cross Society and most of the other hospitals, in addition to subscriptions to the War and Refugees' Funds. The report was unanimously adopted, and a final dividend of 15 per cent. agreed to, making 20 per cent. for the year. At an extraordinary general meeting, subsequently held, sanction was given to increase the capital from £500,000 to £1,000,000 by the creation of 100,000 5 per cent. Preference shares of £5 each, of these 50,000 would now be issued, 25,000 being presented fully paid to the shareholders, and 25,000 offered at par to the proprietors.

The International Medical Congress, 1900.

IN reply to many inquiries, the Executive Committee of the Thirteenth International Congress of Medicine has decided to admit as members of the Congress all dentists who are duly qualified in France or abroad, even though they are not qualified in medicine or surgery. Members of the dental profession who wish to join the Congress will be attached to the section of Stomatology, and are requested to send their applications to the offices of the Congress, 21, Rue de l'Ecole de Medecine, Paris.

London Hospital Medical College.

THE prizes and certificates will be distributed to the students and probationers at the London Hospital this year on July 19th, at 3.30 p.m., in the Library at the College, by Mr. Frederick Treves, F.R.C.S., Consulting Surgeon to the London Hospital, who has recently returned from South Africa. At the same time the new Students' Rooms, Garden Five Court, will be declared open.

Society for Relief of Widows and Orphans of Medical Men.

At the annual general meeting of this society, Mr. Christopher Heath was elected president, and took the chair; Mr. W. H. Bennett and Mr. Manley Sims were elected vice-presidents; and Mr. Borlase Hicks, Mr. Simmonds, Mr. L. Read, Mr. Julian Willis, Mr. Milburn, Dr. Buzzard, and Dr. Morison, to fill the vacancies in the court of directors. The other officers were re-elected. From the report, read by the secretary, it was shown that the grants during the year had amounted to £3,007 10s., the expenses to £243 3s. 1d. The receipts available for payments had been £3,353 7s. 7d.; the grants and expenses, £3,250 13s. 1d., leaving a balance of £102 14s. 6d. No legacy had been received during the year. Fourteen

(a) "The Bacteriology of Everyday Practice." By J. O. Symes, M.D. Lond., D.P.H., &c., Assistant Physician and late Bacteriologist to the Bristol General Hospital. Medical Monograph Series, No. 2. London: Baillière, Tindall, and Cox. 1900. Price 2s. 6d. net.

new members had been elected, and 10 had died and one resigned. Three widows had been placed on the funds and two orphans; four widows had died, and one orphan had become ineligible for further grants, leaving 49 widows and 11 orphans in receipt of grants. The death of Sir James Paget, President, was reported, and of Mr. Mould, V.P. A grant of £26 was made under bye-law 78 to a widow. A vote of thanks to the editors of the Medical journals for their kind advocacy of the interests of the Society was passed. Mr. Christopher Heath returned thanks for his election as President, and the meeting closed.

Accident to a Medical Man.

WHILE cycling between Callington and Tavistock one day last week Dr. Henry Pearse, of Union Street, Plymouth, met with an accident. He remembers passing Gunnislake, but has no knowledge where and when the mishap occurred. He found himself at last in the G.W.R. Station at Tavistock, but did not know how he got there, and he will be grateful if the person who took him to the station would communicate with him. There is much swelling and pain on the right shoulder, but no bones are broken, and the machine was not much damaged.

Medical and Surgical Exhibition.

THE exhibition of medical, surgical, and hygienic appliances which has been held for some years past at the Queen's Hall, Langham Place, W., attracted a considerable number of visitors last week, in spite of the fact that many of the best-known firms still hold aloof. There is certainly scope for an annual exhibition of the kind, provided it is run on proper lines, and it would be difficult to find a more suitable spot than the one chosen, standing, as it does, in close proximity to the medical area surrounding Cavendish Square. There was the usual array of surgical appliances, patent foods, condensed milks, mineral and aerated waters, typewriters, drugs and the like, and the exhibitors must have disposed of an enormous quantity of explanatory literature and free samples, much of which, we imagine, fell into other than medical hands. An excellent feature is the introduction of afternoon and evening concerts which, help to beguile the monotony of the proceedings. As far as one can judge, the exhibition was at least as well patronised as on previous years.

The London and Counties Medical Protection Society, Limited.

THE usual monthly meeting of the London and Counties Medical Protection Society was held on Tuesday, May 29th, at 12, New Court, Lincoln's Inn. The report of the Charity Commissioners in reference to the Leck Cottage Memorial Hospital, concerning which complaint had been made by the society on behalf of one of their members, was laid before the Council, several grave irregularities being dealt with therein. The Council authorised the formation of a new division of the society for the province of Ulster, and approved the list of officials; Dr. Alexander Dempsey, of Belfast, being the first president; and Dr. S. W. Allworthy, secretary. Steps were reported to have been taken for the formation of a Yorkshire division.

The Secretary reported that the General Medical Council had decided to erase from the Dental Register the name of a dentist who had been charged by the society with advertising, this being the first instance in which the General Medical Council had so exercised its powers. One hundred and sixty-six new members have joined the society since the annual general meeting in April last. A very satisfactory financial report was submitted, and several private applications from members were dealt with.

Death of Dr. Mortlock.

AN inquest was held last week on the body of Dr. Mortlock, Medical Officer for the Caldbeck district of the Wigtou Union, who had succumbed to a self-administered dose of hydro-cyanic acid, "whether taken intentionally or by misadventure," said the jury, "we are unable to state." The deceased was only 37 years of age, and had a large practice.

A FIELD hospital, composed entirely of volunteers, left Aldershot Friday morning for Southampton, where

they embarked on the 'Tagus.' They are to do duty with the Rhodesian field force, and for that purpose are all to be mounted. This is the first mounted field hospital sent out.

THE death is announced at the early age of 48 of Mr. George Edward Williamson, F.R.C.S., a well-known north of England specialist in diseases of the eye, from pneumonia, after a brief illness. Mr. Williamson was formerly senior house surgeon and then house physician in the London Hospital, where he was associated with Sir Andrew Clark, Dr. Samuel Fenwick and Mr. Jonathan Hutchinson. He was afterwards senior house surgeon in the Royal Infirmary, Newcastle-on-Tyne, and lecturer on physiology at the Durham College of Medicine.

ACCORDING to the *Daily Chronicle* the V.C. has only been bestowed on 21 members of the Army Medical Staff since its foundation, the latest recruit to the noble array being Major W. Babbie.

DR. F. M. GODDS SMITH, of Redbourn, near St. Albans, was taken ill at a public house last week, and asked permission to lie down. He died soon after, and another medical man who was called in certified death to have been due to apoplexy. An inquest was held, however, when it transpired that the deceased had taken an overdose of morphia. The Coroner, in the absence of the medical man who certified the death, announced his intention of bringing the facts to the notice of the General Medical Council.

AN inquest was held at Wellington (Shropshire) last week on the body of Herbert Plowden Weston, a local practitioner, who died somewhat suddenly a few days after a carriage accident. The evidence revealed the curious fact that the deceased gentleman, though he had sustained a compound fracture of the leg, had persisted in getting about. Death, however, was attributed to advanced visceral disease. Mr. Weston was an old and esteemed practitioner, and his funeral was made the occasion of an imposing demonstration by sympathising friends.

PASS LISTS.

Royal College of Surgeons of England.

THE following candidates having passed the necessary examinations have been admitted members of the College, and have received the diploma of M.R.C.S.:—

Rudolph George Abercrombie, Henry Cyril Adams, Bertram Cecil Robert Aldren, Thomas Shaw Arbuthnot, William Arthur Bailey, Eric George Battiscombe, Charles Thomas Baxter, John Cunningham Bell, Guy Black, Herbert Blackmore, Charles Henry Bradbury, Arthur Hastings Bostock, John Bradford, Arthur Edmund Carver, Charles Henry Bullen, Hewlett Breton, John Beresford Christian, Sidney d'Alton Corbett, John Brocas Chambers Brockwell, Edward Cohen, Thomas Burfield, Edward Revelly Clarke, Arthur Cubley, David Leighton Davies, Charles Maxwell Ekins, Henry Bertram Dismore, Charles Edwards, Meredith Sedgwick Doubble, John Maltby Edwards, William Claughton Douglass, John Scarborough Dudding, Samuel Jonathan David Eesser, Harold St. Clair Elliott, Charles Hy. Fennell, Charles York Flewitt, Horace Wilberforce Freer, Matthias Frederick Foulds, Hugh Watson Fox, Edwin Wallace Goble, Walter Burgess Fry, Shridhar Bheekaji Gadgil, Joseph Marcus Garman, Francisco José Gomez, William Ernest Gribbell, Leslie Haden Guest, Ernest Cutcliffe Hadley, Donald George Hall, James Eder Harper, Sydney George Harrison, Arthur Charles Haslam, Colin Sadler Hawes, Francis Musgrave Howell, Hy. Warwick Illius, Samuel Hey, William Morgan James, Alfred Hewetson, Thomas Higson, John Hoyle, John Lupton Holt, Norman Alexander Aylmer Hughes Archibald Douglas Jameson, Iain Mackinnon Jefferies, Frederick Arthur Johns Alfred Jones, George Joseph Alexis Lecelezio, Frederick Samuel Leech, John Lewis Lock, Frederick William Longhurst, John Augustus Noel Longley, Charles John Nepean Longridge, William James Lord, William Henville Lowman, Frederick John McCann, Louis Charles Martin, Ernest Alfred Miller, Charles Cecil Wildman Mayo, Richard Milnthorpe, Arthur Hy. McNeill Mitchell, Adolph Andreas Christian Mollar, Richard John Morris, James Robert Morton, Reginald Cuthbert Mullins, Sheffield Hy. Morier Neave, Cyril Alfred Rankin Nitch, Thomas Christian Orford, Lionel Edward Orton, Edward Albert Bodenham Poole, William Panckridge Panckridge, Edward Melville Bruce Payne, Charles Robertson Porter, Michael Foster Reaney, Sydney John Peake, Thomas Massey Pearce, Harold Cooper Pretty, Arthur Izod Sheldon, Frederick Schofield Rhodes, Charles Haldane Denny Robbs, Frederick James Faulkland Rooke, John Salmon Smith, Cuthbert Fenness Selous, Hugh Frederick Sheldon, George Herbert Simpson, Stephen Francis Smith, Alfred Bertram Soltau, Hy. Edmund Symes-Thompson, Percy Tatchell, Albert John Walton Wells, William Irwin Taylor, Basil Hubert Howard Tripp, Hardy Vesey Wells, Harold Arthur Upward, Francis Peter Veyra, Cyril Charles Coleby Kirke White, Edward White, Thomas Wood, and William John Young.

Notices to Correspondents, Short Letters, &c.

✎ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a distinctive signature or initials, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

PLEXUS. A serviceable application in cases of earache is the following: Five parts of camphorated chloral, thirty parts of glycerin, and ten parts of the oil of almonds. A plug of cotton saturated with this is gently pushed into the painful ear, and left in contact. This, of course, is only a temporary expedient, and does not dispense with the necessity for making a careful examination of the organ in order to ascertain the actual use of the pain.

GUTHRIE'S WIT.

SIR JOSEPH FAYRE in his *Memoir* tells a good story of Guthrie, the authority on military surgery of those days:—

One day, when we were going round the wards with a large following of distinguished visitors, foreign surgeons, and others, we stopped at an interesting case, where he found fault with the dresser for something he had done or left undone. The student made some reply, and Guthrie said, "I daresay you think yourself a devilish clever fellow, don't you?" "No, sir, I don't," was the reply. "But you are though," said Guthrie; and we passed on.

THE VIR PUBLISHING COMPANY.—We are unable to accede to your request; it is an advertising matter pure and simple.

MR. STANLEY BARLING is thanked for his report of case, for which we hope to have space in our next.

DR. H. B. (Paris).—Note received and necessary arrangements made.

MR. FELIX ALCAN (Paris).—Enquiry is being made; the result will be communicated.

DR. R. H. S.—We think it would be somewhat late now to send the patient to the place mentioned. Would advise Harrogate or Buxton for the next three months. Aix-les-Bains would be desirable in September and October.

S. G. F.—The subject of asylum service was exhaustively treated in these columns in a series of leading articles running through the months of March and April last.

MENTOR (Liverpool).—It is clear from your own admission that your nervous system is on the point of breaking down. Under such circumstances an absolute change of scene and cessation of all work is imperative. Our advice is: Drop all professional pursuits, and go off and live in a farmhouse or in some quiet seaside place for a month. Fish, shoot, row, take long walks, live in the open air as much as possible. All this is the advice you would give to patients. Of course, it is difficult to get away, but such an investment will repay any sacrifice on your part.

TWINKLER.—Starch, boric acid, oxide of zinc, of each two drachms; salicylic acid, grs. x. Dust the parts well night and morning. Use hot water and carbolic soap previously.

Meetings of the Societies and Lectures.

THURSDAY, JUNE 14TH.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.—8 p.m. Cases and Card Specimens. 8.30 p.m. Papers.—Mr. W. H. Jessop: Embolism of Both Central Arteries of the Retina. Mr. C. Way: The Development of Myopia. Mr. S. Snell: 1. Congenital Papilloma of the Conjunctiva; 2. Periarthritis of the Central Artery of the Retina; 3. Work of Forest Scenery (illustrated from paintings by an amateur artist who had previously undergone cataract extraction.) Mr. S. Stephenson: A Case of Ophthalmitis associated with Basil Meningitis.

BRITISH GYNÆCOLOGICAL SOCIETY (20, Hanover-Square, W.)—Specimens will be shown by Dr. Elder and Mr. Furness Jordan. Discussion on Indications for the Removal of the Uterine Appendages.

FRIDAY, JUNE 15TH.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.—Mr. E. M. Gunn on Visual Sensations. (Bowman Lecture.)

Appointments.

BENNETT, F. T., M.B.C.S., Medical Officer for the Ham and Coombe Sanitary Districts of the Kingston Union.
BERRY, T. P., M.B.Lond., L.R.C.P., M.B.C.S., Second Assistant Medical Officer of the St. Saviour's Infirmary, Dulwich.
COSTELLO, M. J. B., M.B., B.Ch.Ire., Medical Officer for the Workhouse and Dispensary District of Glenamaddy.
COURT, E. P., L.R.C.P.Lond., M.B.C.S., Medical Officer for the Sanitary District of Hambledon, Droxford Union.
GIMSON, K. C., M.B., B.C.Cantab., Medical Officer *pro tem.* by the Witham Urban District Council.
HARRISON, E. T., L.R.C.P.Lond., M.B.C.S., Medical Officer for the Second Sanitary District of the Parish of St. Georges-in-the-East, London.
HAY, T. W., M.B., C.M.Glasg., Medical Officer for the No. 5 Sanitary District of the Newcastle Union.
KELSON, W. H., M.D., B.S.Lond., F.R.C.S., Honorary Surgeon in charge of the Throat, Nose and Ear Department, City Dispensary, London, E.C.
KING, J., L.R.C.P. Edin., M.B.C.S., Medical Officer of Health by the Bude and Stratton Urban District Council.
KNOWLES, BEATRICE, M.B., B.S.Lond., Second Assistant Medical Officer for the new Infirmary, Bethnal Green.

POMFRET, H. W., M.D.Vict., F.R.C.S., Medical Officer for the Eighth Sanitary District of the Ashton-under-Lyne Union.
PRIESTLEY, C. E., L.R.C.P. Edin., M.B.C.S., Medical Officer for the Workhouse of the Thingoe Union.
ROBERTS, J. LLOYD, M.D., R.S., B.A., B.Sc.Lond., F.R.C.S., Honorary Physician to the Liverpool Stanley Hospital.
SMITH, ALFRED CHARLES FESTING, L.R.C.P., L.R.C.S. Edin., L.F.P.S.Glasg., Civil Surgeon *pro tem* to the Medical Charge of Troops at Bull Point, Plymouth.

Vacancies.

Bootle Hospital for Infectious Diseases.—Resident Medical Superintendent, unmarried. Salary £120 per annum, with board, washing, and apartments in the hospital. Applications to the Chairman of the Hospital Sub-Committee, Town Hall, Bootle.
Bristol Royal Hospital for Sick Children and Women.—House Surgeon. Salary £120 per annum, with rooms and attendance (not board).
County Asylum, Whittingham, Lancashire.—Junior Assistant Medical Officer, unmarried. Salary commencing at £125 per annum, with furnished apartments, board, attendance, and washing.
Corporation of Birmingham—City Hospital, Lodge Road.—Assistant Medical Officer. Salary £120 per annum, with board, residence, &c.
Cotswold Sanatorium for the Open-Air Treatment of Tuberculosis.—Assistant Medical Officer. Salary to commence at £120 per annum and all found. Apply to Dr. S. T. Pruett, Sherborne Lodge, Cheltenham.
County Asylum, Rainhill, near Liverpool.—Assistant Medical Officer, unmarried. Salary commences at £125 per annum, with prospect of increase to £250, with furnished apartments, board, attendance and washing.
Devonshire Hospital, Buxton, Derbyshire.—House Surgeon and Assistant House Surgeon for twelve months. Salary of House Surgeon £100 per annum. Assistant House Surgeon £50, with furnished apartments, board, and washing in both cases.
General Hospital, Birmingham.—Pathologist, subject to annual re-election for five years. Salary £100 per annum with board and residence.
Great Northern Central Hospital, Holloway Road, London.—House Physician and Junior House Physician, both for six months. Salary of House Physician at the rate of £60 per annum. Also Junior House Physician for six months at the rate of £30 per annum, with board, lodging, and washing in the hospital in each case. (See advt.)
Kensington Dispensary.—Resident Medical Officer, unmarried. Salary £125 per annum, with furnished apartments, coals, gas and attendance. Applications to the Honorary Secretary, 56, Bedford Gardens, Camden Hill, Kensington, W.
Loughborough and District General Hospital and Dispensary, Loughborough.—Resident House Surgeon. Salary £100 per annum, with furnished rooms attendance, and board.
Northampton General Infirmary.—House Surgeon, unmarried. Salary £125 per annum, with furnished apartments, board, attendance and washing.
North Riding Asylum, Clifton, York.—Senior Assistant Medical Officer, unmarried. Salary £125, rising £10 annually to £175, with board, furnished apartments, washing and attendance.
Nottingham General Dispensary.—Assistant Resident Surgeon, unmarried. Salary £140 per annum, all found except board.
Wolverhampton and Staffordshire General Hospital.—House Surgeon. Salary £100 a year, with board, lodging, and washing.
York Dispensary.—Resident Medical Officer, unmarried. Salary, £110 a year, with board, lodging, and attendance.

Births.

BOYD WALLIS.—On June 8th, at Melville Lodge, Brentwood, the wife of Albert W. Boyd-Wallis, M.B.C.S., of a son.
BURROWS.—On June 2nd, at the Haven, Harrow, the wife of Harold Burrows, M.B., of a son, who only survived his birth a short time.
GREY.—On June 3rd, at Strathtay, Perthshire, N.B., the wife of Harry Grey, M.B., C.M., San Remo, Italy, of a son.
PHILLIPS.—On June 7th, at 10, Long Street, Devizes, the wife of George C. Phillips, M.A., M.D.Cantab., of a son.
SMITH.—On June 3rd, at Lynton House, Warrington, the wife of Reginald Smith, M.B.C.S., L.R.C.P., of a daughter.

Marriages.

GILPIN—BOTT.—On June 6th, at the Parish Church of St. Pancras London, William John Gilpin, M.B.C.S., L.R.C.P., of Brook Lodge, Bourne, to Ada, widow of the late Arthur Bott, of Bourne, Lincolnshire.
LOGAN—CHAMBERLAIN.—On June 6th, at the Parish Church, Solihull, Warwickshire, Roderic Robert Walter Logan, M.B.C.S., of Ashby-de-la-Zouch, to Frances Ethel, youngest daughter of George K. Chamberlain, of Leamington House, Malvern Wells.
SESSIONS—COLLINSON.—On June 6th, at the Friends' Meeting House, Halifax, Frederick Leonard Sessions, M.B.C.S. Eng., L.R.C.P.Lond., of Evesham, Wors., to Ethel Mary, only daughter of Joseph Collinson, of Halifax, Yorks.
WADE—GREGORY.—On June 2nd, at St. John's Church, Upper St. Leonards-on-Sea, Charles H. Wade, M.A.Oxon., M.B.C.S., F.L.S., of Royal Terrace, Southend-on-Sea, to Eva, only surviving child of the late Rev. A. T. Gregory, formerly Rector of Trusham.

Deaths.

FITZ-PATRICK. On May 31st, at Sussex Gardens, Hyde Park London, Thomas Fitz-Patrick, M.D., M.B.C.P.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

VOL. CXX.

WEDNESDAY, JUNE 20, 1900.

No. 25

Berlin Clinical Lectures.

THE NATURE AND TREATMENT OF ANÆMIAS. (a)

By Dr. SENATOR,
Of Berlin.

AFTER some preliminary remarks the lecturer observed that these had been the object of a good deal of investigation during recent years. There was scarcely any form of disease in the course of which anæmias might not occur, and when they might be disguised by some colouration of the skin such as icterus, or bronzing. There were primary essential or idiopathic anæmias, and secondary, the consequences of loss of blood, acute or chronic poisonings, or serious organic disease.

The border-line between primary and secondary anæmias was not strictly defined. Anæmias at first secondary in consequence of hæmorrhage, might continue after the cessation of the hæmorrhage; they might take on a pernicious character and behave like primary diseases. Anæmias caused by intestinal parasites were secondary. Naturally as we succeeded in discovering the causes of anæmia the range of the primary disease became more restricted, and it was to be hoped that the causes of all would yet be discovered.

Before arriving at a diagnosis of essential anæmia, all causes should be excluded. There were some diseases that lead to anæmia that remain long hidden; tuberculosis might remain long latent, and only show itself by anæmia, and the same with carcinomata of the abdominal organs, and especially carcinoma and malignant new growths of the bones and bone marrow. These latter affections should be suspected when no cause for an anæmia could be found. In any doubtful case, the attention should be directed to three points: the faces must be examined for parasites, and then any possible hæmorrhage investigated. Hæmorrhage was often overlooked especially intestinal hæmorrhage from high lying ulcers. These coloured the stools a little more darkly and then might not strike the patient. Then the morphotic changes of the red blood corpuscles were to be considered.

For our climate only the malaria plasmodia need be considered, but for tropical regions the filaria sanguinis and the distomum hæmatobium were to be reckoned with. The latter parasite had not been seen in the peripheral blood courses, but only in the liver and perhaps also the renal blood vessels.

Thirdly, we should never delay in examining the motor and chemical functions of the stomach. It was known that in many cases of grave anæmia a peculiar change took place in the glands of the stomach, and the stomach secretion was in abeyance. It had been believed that anæmia was a result of achylia, but this was not so. The stomach might be completely re-

moved without nutrition suffering or anæmia following. Changes in the intestines must also be found; they were sometimes, but not often. Inversely extensive changes might be found without anæmia, a causal relationship could not therefore be proved. The reverse of this had been assumed, viz., that the stomach and intestinal changes took place in consequence of the anæmia. According to the speaker both must be looked upon as the coordinate action of other causes.

In some cases the cause could not be discovered. Ehrlich and Lazarus had observed four cases that presented all the features of essential anæmia, in which after death cancer of the stomach had been found. They were of opinion that the anæmia had furnished the soil for the development of the carcinoma. O. Israel, who had examined a similar case, thought that unnoticed hæmorrhage had led to the anæmia. The speaker thought that the simultaneous occurrence of cancer and anæmia might sometimes be accidental. This was not the case, however, with myeloma. Considering the importance of the bone marrow for the development of blood, it must be taken for granted that the malignant disease led to the anæmia.

Chlorosis and pernicious anæmia were generally considered to be essential anæmias. But there was a third, little-known disease, that with greater right belonged to the class—mountain disease, anæmia montana, for as regarded the two others it could scarcely be doubted that the causes were not in the blood but outside it, especially in the case of chlorosis. The causes of this were said to lie in the digestive tract; others threw the blame on an autointoxication proceeding from the ovaries. V. Noorden also placed the starting-point in the ovaries, believing that the normal ovary furnished a secretion to the blood that stimulated the bone marrow and glands; this secretion was absent in chlorosis. Examination of the urine should not be forgotten.

As regarded treatment, iron was justly looked upon as a specific remedy. But in many cases iron failed. It must be borne in mind, however, that iron was often given at an improper time, when the stomach might be very sensitive, or it might set up catarrh and make the condition worse. Hydrochloric acid was then very useful. The speaker preferred the saline ferruginous waters; they were borne better, and acted on the stools. But they should not be given fasting, and should be given warmed. Small doses also should be begun with 200 to 250 grms. Later on they might be given cold, to the amount of a litre a day. Such saline iron springs were Franzensbad, Elster, Tarasp, &c. Naturally the waters were best drunk on the spot. Such waters were not suitable for home treatment, as they readily decomposed. For home treatment, the artificial pyrophosphoric acid iron water was the best.

Of pharmaceutical preparations the number was great. Iron was best given in combination with organic acids, lactic, citric, acetic, malic. These were readily digestible, and did not constipate, like the mineral

(a) Abstract of an address delivered to the Hufeland Society.

acids. For nervous persons, spts. ferri chlorat. æth., under the name of Tinctura Bestuscheffii.

But there were cases where these means failed; he had seen good from sweating, it often helped when other means failed. It was especially to be noticed as it had had the best results in out-patient treatment. Hot baths were ordered, or better still, hot-air baths, which could be given at home by suitable appliances. Dyes said that venesection depended on it causing sweating for its good effects.

As regarded the treatment of pernicious anæmia the hygienic conditions were to be more carefully looked after, and iron, arsenic and bone marrow preparations were to be given.

The third form was the anæmia montana. Here the actual changes were in the blood only. The blood became poor in oxygen, anoxymia, giddiness, palpitation of the heart, vomiting, hæmorrhage from various organs were the characteristics. The red blood corpuscles were increased. Mountain anæmia was only an acute condition. The specific treatment was that those attacked should descend to a lower level, or that acclimatisation should be waited for. Oxygen inhalations were well adapted for treatment of the attack.

In the discussion that followed Hr. Ewald said that the cause of pernicious anæmia might be complete erosion of the stomach and intestinal glands. If the intestinal tract was examined bit by bit a widespread atrophy of the glands would some times be found. There could be no essential anæmia. He preferred arsenious acid with iron and quinine. For pernicious anæmia transfusion should be mentioned.

Hr. Patschkowski considered regular evacuation to be very important. He ordered enemata with common salt; a portion of it was absorbed and acted like transfusion. He had seen very good results. Chlorotics should rather rest in the open air than walk too much, and respiration gymnastics were useful.

Hr. Schlesinger had seen no permanent results from hot baths; the old condition returned in a few months.

Hr. Senator observed that that was the case with regard to all the other remedies recommended; there was no certain treatment that promised a permanent recovery.

ASYLUM PATHOLOGY. (a)

By DR. W. R. DAWSON.

THE modern conception of insanity as the mental manifestation of physical disorder inevitably points to the necessity for study of the morbid changes in the brain and nervous system which accompany mental disease. So much is this the case that it is now held by everyone whose opinion is worth serious consideration that the only chance of acquiring such knowledge as can lead to the more effectual prevention and treatment of insanity lies in increased attention to cerebral pathology. But this is no easy matter to accomplish, owing both to the inherent difficulty of the subject and to the nature of the methods required in its investigation.

It need hardly be said that to understand the pathology of any organ a previous knowledge of its normal anatomy and physiology is indispensable, and that in the case of the brain such an intimate knowledge is very difficult to acquire, not only on account of the infinite complexity of the organ itself, but because so many of the most important points are still *sub judice* that the controversial literature has swollen to enormous dimensions. Yet the

mastery of this subject is a mere preliminary. Again, the study of cerebral pathology involves the use of some of the most difficult and lengthy of histological and other methods, and here again the mass of work being done in this field all over the world necessitates an acquaintance with foreign languages, and a large amount of time devoted solely to keeping up with the literature of the subject. The conclusion to which all these facts lead is that for real progress such a degree of knowledge, skill, and experience, and such an amount of time, are required as can only be obtained by inducing specially-trained pathologists to devote themselves entirely to the subject. How can this be managed?

In many of the English and Scottish asylums there is, very properly, a resident pathologist, with a laboratory at his disposal, who is responsible for the pathological work of the institution. But in the bulk of the smaller asylums no such arrangement exists, and only one of the Irish asylums has even a nominal pathologist. Moreover, even where there is a special pathologist he is usually simply the junior assistant, and is expected to combine with his pathological duties a not-inconsiderable amount of clinical and administrative work. In addition to this, there being no prospect of advancement in his particular line, he usually, in a year or two, just as he has acquired some real knowledge and skill, accepts promotion to a higher assistantship, dropping to a large extent his pathological studies. However desirable, therefore, it may be to have resident pathologists for the routine work of asylums, it is obvious that this arrangement does not fulfil the conditions requisite to our advance in knowledge, while in the bulk of the asylums it is, for financial reasons, impossible.

The only alternative is that which was adopted by the London County Council, who, in 1892, took steps for the establishment of a central laboratory for the seven asylums under their control. This laboratory they have splendidly equipped and placed under the direction of a scientific man in every way competent to fill the post, Dr. F. W. Mott, F.R.S., giving him an adequate salary. This experiment has been a complete success. Not only has most excellent work been done, as shown by the first number of the "Archives of Neurology," which emanates from the laboratory, but, as Dr. Mott states, his "appointment appears to have been an incentive to pathological work of other asylums;" and I may add that a special clause has been inserted into the new English Lunacy Bill, authorising the combination of asylums for the purpose of establishing similar laboratories. Stimulated by this good example a number of the Scottish asylums also united, in 1896, to start a conjoint laboratory in Edinburgh, under the control of Dr. Ford Robertson, whose work was already becoming known. The duties of the post were stated to be:—

1st. To carry on original researches upon the pathology of insanity.

2nd. To examine pathological material sent from the asylums and to furnish reports.

3rd. To teach and give assistance to members of the medical staff of the associated asylums in regard to research-work upon the pathology of insanity, by suggesting subjects, collecting material, advising methods, assisting with reference to literature, providing demonstration sets of specimens, and visiting the associated asylums at intervals.

4th. A reference library of neurological literature was also to be collected.

This scheme, which has now been joined by seventeen of the Scottish asylums, has been from the first a success. Numerous papers have been published from the laboratory, the course of instruction there has largely been taken advantage of, and, in short, the objects above detailed have been carried out. In

(a) Paper read at Meeting of Royal Academy of Medicine in Ireland, in the Section of State Medicine, April 27th, 1900.

fact we learn from the last report that a movement is on foot to augment the laboratory by the addition of a separate department for pathological chemistry under distinct control.

I may just allude to the magnificent Pathological Institute of the New York State Hospitals, with its eight departments, each under the charge of a specialist, as showing the extent to which this principle of conjoint asylum laboratories has been pushed elsewhere. But let us now look at our own asylums, and see how the scheme would apply here.

I have shown above that the system of separate pathologists for asylums is not a satisfactory solution of the problem. In this country, except in two or three cases, it is not even possible, for some of the asylums have no assistant medical officer, and others only one, so that separate pathologists would be altogether out of the question for reasons of expense. On the grounds of economy alone, therefore, a central laboratory seems indicated. The annual expenditure of the Scottish laboratory, which seems to approximate almost exactly to our requirements, is about £600 a year. In this country there are 23 district asylums and several other public asylums, such as the Central Criminal Asylum, St. Patrick's Hospital, and the Stewart Institution, not to mention a number of private asylums; and if all these, or a good majority of them, were to join the scheme, the individual contributions would be comparatively insignificant. The matter, therefore, appears feasible, and some steps have already been taken to carry it into effect.

The idea was publicly mooted for the first time in the Inaugural Address delivered by me last November, as President of the D. U. B. A., on which occasion it met with the approval not only of Dr. Aldren Turner of London, the guest of the evening, but also of the *Lancet*, in its notice of the meeting. Later in the session I brought the subject prominently before the Association, who passed a unanimous resolution in favour of the scheme; and lastly, it was the subject of a discussion at the meeting of our division of the Medico-Psychological Association of Great Britain and Ireland on April 10th, on which occasion it was resolved, without a dissentient:—

"That, for the better carrying on of the pathological work of the Irish Asylums, and for the encouragement of original research in the pathology of nervous and mental disease, it is desirable to establish a central laboratory devoted to these special ends, under the management of a competent pathologist, who shall give all his time to this work; and that a committee of five Asylum Superintendents be appointed to take steps to give effect to this resolution."

A committee was accordingly appointed, consisting of Drs. Conolly Norman, Finegan, Woods, Graham, and the writer, and steps are now being taken to push the matter forward without undue delay. The scheme, as at present shaped out, being almost identical in its objects with that in Scotland, but with this addition, that the Institution is also to serve the purpose of a clinical research laboratory for the associated asylums.

I have ventured to bring this subject under your notice to-night in the hope of enlisting the sympathies of the Academy on behalf of this very necessary enterprise, because its success or failure almost certainly rests ultimately with the asylum boards, and in endeavouring to influence them it is more than desirable to show that we have with us the outside profession, that this is not a mere specialist's chimera, but a scheme important to the well-being of the thousands of unhappy sufferers from insanity in the country, and stamped with the approval of all enlightened scientific opinion.

MALARIA AND MOSQUITOES. (a)

By MAJOR RONALD ROSS, D.P.H., M.R.C.S.

THE importance of the malarial problem need not be enlarged upon. In the British army in India during the year 1897, out of a total strength of 178,197 men, no less than 75,821 were admitted into hospital for malarial fever! Fortunately the death-rate of the disease is low in most places; but on the other hand the cases are so numerous that in the aggregate the mortality from malarial fever is very large indeed. For instance, in India alone, among the civil population (who do not take adequate treatment), the mortality from "fevers" during the single year 1897 amounted to the enormous total of 5,026,725—over five million deaths—being nearly ten times that due to any other disease. Although undoubtedly thousands of deaths are wrongly attributed to fever in these statistics, such figures can point only to a very great mortality due to malaria. Yet India on the whole is not nearly so malarious as many localities—such, for instance, as places on the coasts of Africa. In short, next perhaps to tuberculosis, malarial fever is admittedly the most important of human diseases.

Lancisi and Pringle connected the disease with stagnant water, and their views have been generally endorsed by innumerable observations made since their time. But Laveran had now shown the disease to be due to a parasite of the blood. There appeared to be but one way of reconciling these facts, namely, by supposing that the organism lives a free life in the water or soil of malarious places, from which it enters man by the respiratory or digestive tracts. To prove this it was necessary to discover it in the water or soil of malarious places. But the organism is not a bacterium, but an animal parasite. It cannot be taken from the living blood and sown on the surface of a gelatine film. Experiments have proved that it can be inoculated from man to man by the intravenous injection of fresh infected blood; but this is a very different thing to cultivating it in an artificial medium. The parasites simply perish when taken from their natural habitation, the blood. It was therefore extremely unlikely that we should ever be able to follow up their life-history by this means—which has proved so successful as regards the bacteria.

Since the original discovery of Ray Lankester, numerous hæmatozoa—or rather hæmocytozoa—have been found in man and various animals. All these are generally classed by zoologists in Leuckart's order of the sporozoa, and are usually divided into three groups—groups which are not very closely related, except for the fact that all the organisms concerned are parasites of the red corpuscles of the blood. One group—found in reptiles—consists of parasites closely allied to the Gregarinidæ, another is found in oxen, and is the cause of Texas cattle fever; the third, for which I adopt the name of hæmamœbidæ Wassielewski, is found in man, monkeys, bats and birds. It is to this third group—the hæmamœbidæ—to which we must now direct our attention, because it includes the parasites of malarial fever. There are, at least, two known species found in birds, two in bats, one in monkeys, and three in man. The human parasites are those which respectively cause the three varieties of malarial fever—quartan, tertian, and remittent or pernicious fever. From these three species I adopt the names hæmamœba malaris (quartan), hæmamœba vivax (tertian), and hæmomenas præcox (remittent fever). According to Metchnikoff the group belongs, or is allied, to the coccidiidæ. All the species have a close resemblance to each other, and all contain the typical melanin of malarial fever. The youngest parasites are found as minute amœbulæ living within the red corpuscle and generally containing granules of this melanin (which, indeed, is derived by the parasite from the hæmoglobin of the corpuscle within which it makes its abode). The amœbulæ grow rapidly in size, until, after one or more days (according to the species) they reach maturity. At this point many of them become sporocytes—that is, give rise to ordinary spores by vegetable reproduction. These spores presently

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attach themselves to fresh corpuscles, become fresh amœbulae, and so continue the life of the parasites indefinitely within the vertebrate host. Others of the amœbulae, however, instead of becoming sporocytes like the rest, become gametocytes.

Now it is to these gametocytes that an extreme interest attaches, because it is to them, and to Manson's study of them, that we owe the solution of the malarial problem. Numerous observers had examined them before Manson's time, but all had failed in arriving at a correct idea as to their function. It had been often observed that they circulate in the blood of the vertebrate hosts without, apparently, performing any function at all. As soon, however, as they are drawn from the circulation—as when the blood containing them is made into a fresh specimen for microscopic examination—they undergo the most remarkable changes. They swell up and liberate themselves from the enclosing corpuscle; and then some of them are suddenly seen to emit a number of long motile filaments. These filaments can easily be watched struggling violently, and may sometimes be seen to break from the parent cell and to dart away among the corpuscles, leaving the residue of the gametocyte, with its melanin, an inert and apparently dead mass.

Now it is not to be supposed that such an extraordinary phenomenon as this—which was observed by Laveran during his first investigations—could be witnessed without exciting the liveliest curiosity. As a matter of fact, a hot controversy rose regarding it. Laveran, Danilewsky and Mannaberg maintained that the phenomenon is a vital one—that the motile filaments are living organisms, and constitute a stage in the history of the parasite. Antolisei, Grassi, Bignami and others of the Italian school fell back upon the old theory—which we always like to employ when we cannot explain a phenomenon—that it is a regressive phenomenon, a disintegration of the parasite due to its death *in vitro*. Here, however, the controversy practically stayed. While the Italians, in conformity with their views, attached no signification to the motile filaments, Laveran, Danilewsky and Mannaberg, who held an opposite opinion, did not expressly or exactly state what their signification is. Mannaberg, indeed, held that they are meant to lead a saprophytic existence, but did not explain how they could escape from the body in order to do so.

It was reserved for Manson to detect the ultimate (though not the immediate) function of these bodies. He asked why the escape of the motile filaments occurs only after the blood is abstracted from the host (a fact agreed upon by many observers), and the result of his investigations was to show that the phenomenon, though it is usually observed in a preparation for the microscope, is really meant to occur *within the stomach cavity of some suctorial insect, and constitutes the first step in the life-history of the parasite outside the vertebrate host*.

It was from the first impossible to consider the subject in the light in which Manson placed it without feeling convinced that the parasite requires a suctorial insect for its further development, and subsequent events have proved Manson to have been right.

The most evident reasoning—the connection between malarial fever and low-lying water-logged areas in warm countries—suggested at once that the suctorial insect must be the gnat (called mosquito in the Tropics).

I may remark that Manson thought the motile filaments to be of the nature of zoospores—that is, motile spores which escape from the gametocytes in the stomach cavity of the gnat, and then occupy and infect the tissues of the insect. In this he was proved, two years later, to have been wrong. The motile filaments are not spores, but microgametes—that is, bodies of the nature of spermatozoa. I have said that some of the amœbulae in the blood corpuscles of the host become sporocytes, which produce asexual spores (nomospores); while other amœbulae become gametocytes, which have no function within the vertebrate host. As soon, however, as these gametocytes are ingested by a suctorial insect they commence their proper functions. As their name indicates, they are sexual cells—male and female. About fifteen minutes after ingestion (in some species),

the male gametocyte emits a variable number of microgametes—the motile filaments—which presently escape and wander in search of the female gametocytes. These contain a single macrogamete or ovum, which is now fertilised by one of the microgametes, and becomes a zygote. We owe this beautiful discovery to the direct observation of MacCallum (1897), confirmed by Koch and Marchoux, and indirectly by Bignami. Metchnikoff, Simond, Schaudinn, and Siedlecki have also demonstrated what are practically sexual elements in some of the coccidiidae. Directly MacCallum's discovery was announced Manson saw the important bearing of it on the mosquito theory. Admitting that the motile filaments themselves do not infect the gnat, he at once observed that it was probably the function of the zygote to do so—and this time he was perfectly right.

I must now turn to my own researches. Dr. Manson told me of his theory at the end of 1884, and I then undertook to investigate the subject as far as possible. I began work in Secunderabad, India, in April, 1895. The method adopted—the only method which could be adopted—was to feed gnats of various species on persons whose blood contained the gametocytes, and then to examine the insects carefully for the parasites which by hypothesis the gametocytes were expected to develop into. This required not only familiarity with the histology of gnats, but a laborious search for a minute organism throughout the whole tissues of each individual insect examined—a work of at least two or three hours for each gnat. But the actual labour involved was the smallest part of the difficulty. Both the form and appearance of the object which I was in search of, and the species of the gnat in which I might expect to find it, were absolutely unknown quantities. We could make no attempt to predict the appearance which the parasite would assume in the gnat; while owing to the general distribution of malaria fever in India, the species of insect concerned in the propagation of the disease could scarcely be determined by a comparison of the prevalence of different kinds of gnat at different spots with the prevalence of fever at these spots. In short, I was forced to rely simply on the careful examination of hundreds of gnats, first of one species and then of another, all fed on patients suffering from malarial fever—in the hope of one day finding the clue I was in search of.

As a matter of fact, for nearly two and a half years my results were almost entirely negative. The experiments with the two commonest kinds of culex, were once more repeated, only to prove again negative. The insects, fed mostly on cases containing the crescentic gametocytes of *hæmomenas præcox*, were examined cell by cell—not even their excrement being neglected. Although they were known to have swallowed living hæmamebidae, no living parasites like these could be detected in their tissues—the ingested hæmamebidae had in fact perished in the stomach cavity of the insects.

One day in some larvae brought by a native from an unknown source, I found a number of newly-hatched mosquitoes like those first observed by me in the Sigur Ghat—namely, mosquitoes with spotted wings and boat-shaped eggs. Eight of these were fed on a patient whose blood contained crescentic gametocytes. Unfortunately I dissected six of them either prematurely or otherwise unsatisfactorily. The seventh was examined, on August 20, 1897, cell by cell; the tissues of the stomach (which was now empty owing to the meal of malarial blood taken by the insect four days previously being digested) were reserved to the last. On turning to this organ I was struck by observing, scattered on its outer surface, certain oval or round cells of about two to three times the diameter of a red blood-corpuscle—cells which I had never before seen in any of the hundreds of mosquitoes examined by me. My surprise was complete when I next detected within each of these cells a few granules of the characteristic coal-black melanin of malarial fever—a substance quite unlike anything usually found in mosquitoes. Next day the last of the remaining spotted-wing mosquitoes was dissected. It contained precisely similar cells, each of which possessed the same melanin, only the cells in the second mosquito were somewhat larger than those in the first.

These fortunate observations practically solved the

malaria problem. As a matter of fact, the cells were the zygotes of the parasite of remittent fever growing in the tissues of the gnat; and the gnat with spotted wings and boat-shaped eggs in which I had found them belonged (as I subsequently ascertained) to the genus *Anopheles*.

Early in 1898, mainly through the influence of Dr. Manson, Sir H. W. Bliss and the United Planters' Association of Southern India, I was placed by the Government of India on special duty in Calcutta to continue my investigations. Unable to work with human malaria—chiefly on account of the plague scare in Calcutta—I turned my attention to the hæmamebids of birds. Birds have at least two species of hæmamebids. I subjected a number of birds containing one or the other of these parasites to the bites of various species of mosquitoes. The result was a repetition of that previously obtained with the human parasites. Pigmented cells precisely similar to those seen in the anopheles were found to appear in gnats of the species called *Culex fatigans*, Wiedemann, when these had been fed on sparrows and larks containing hæmameba *relicta*. On the other hand, these cells were never found in insects of the same species when fed on healthy birds or on birds containing the other parasite, called hæmameba *danilewskii*.

It will be evident that this fact was the crucial test both as regards the parasitic nature of these cells and as regards their development from the hæmocytozoa of the birds; and it was not accepted by me without very close and laborious experiment. The actual results obtained work as follows:—

Out of 245 *Culex fatigans* fed on birds containing *H. relicta*, 178, or 72 per cent., contained "pigmented cells." But, out of 41 *Culex fatigans* fed on a man containing crescentic gametocytes, five on a man containing immature tertian parasites, 154 on birds containing *H. danilewskii*, 25 on healthy sparrows, and 24 on birds with immature *H. relicta*—or a total of 249 insects, all carefully examined—not one contained a single "pigmented cell."

Another experiment was as follows:—Three sparrows, one containing no parasites, another containing a moderate number of *H. relicta*, and the third containing numerous *H. relicta*, were placed in separate cages within three separate mosquito curtains. A number of *Culex fatigans*, all bred simultaneously from larvae in the same breeding bottle, were now liberated on the same evening partly within the first mosquito netting, partly within the second, and partly within the third. Next morning many of these gnats were found to have fed themselves on the birds during the night. Ten of each lot of gnats were dissected after a few days, with the following result:—

The ten gnats fed on the healthy sparrow contained no "pigmented cells." The ten gnats fed on the sparrow with a moderate number of parasites were found to contain altogether 292 "pigmented cells;" or an average of 29 in each gnat. The ten gnats fed on the sparrow with numerous parasites, contained 1,009 "pigmented cells;" or an average of 100 cells in each gnat. These 30 specimens were sent to Manson in England, who made a similar count of the cells.

I may mention one more out of several experiments of the same kind. A stock of *Culex fatigans*, all bred from the larva, were fed on the same night partly on two sparrows containing *H. relicta*, and partly on a crow containing *H. danilewskii* (placed, of course, under separate mosquito-nettings). Out of 23 of the former lot, 22 were found to have pigmented cells; while out of 16 of the latter, none had them.

It remained to follow out the life-history of the zygotes. For this purpose it was immaterial whether I worked with the avian or the human parasites, since these are so extremely like each other. I elected to work with the avian species, chiefly because the plague-scare in Bengal still rendered observations with the human species almost impossible. By feeding *Culex fatigans* on birds with *H. relicta* and then examining the insects one, two, three and more days afterwards, it was easy to trace the gradual growth of the zygotes.

But a most important point still required study. What

happens after the zygotes reach maturity? I found that each zygote as it increases in size divides into meres, each of which next becomes a blastophore, carrying a number of blas's attached to its surface. Finally the blastophore vanishes, leaving the thick capsule of the zygote packed with thousands of the blasts. The capsule now ruptures, and allows the blasts to escape into the body fluids of the insect.

As I have said, the zygotes become ripe and rupture about a week after the insect was first infected—scattering the blasts into the body cavity of the host. It was next seen that by some process, apparently owing to the circulation of the insect's body-fluids (for the blasts themselves appear to be almost without movement), these little bodies find their way into every part of the mosquito—into the juices of its head, thorax, and even legs. Beyond this it was difficult to go. All theory—at least all theory which I felt I could depend upon—had long been left behind, and I could rely on direct observation. Gnat after gnat was sacrificed in the attempt to follow these bodies. At last, while examining the head and thorax of one insect, I found a large gland consisting of a central duct surrounded by large grape-like cells. My astonishment was great when I found that many of these cells were closely packed with the blasts—which I may add are not in the least like any normal structures in the mosquito. Now I did not know at that time what this gland is. It was speedily found, however, to be a large racemose gland consisting of six lobes, three lying on each side of the insect's neck. The ducts of the lobes finally unite in a common channel which runs along the under surface of the head and enters the middle stylet, or lancet, of the insect's proboscis.

It was impossible to avoid the obvious conclusion. Observation after observation always showed that the blasts collect within the cells of this gland. It is the salivary or poison gland of the insect, similar to the salivary gland found in many insects, the function of which, in the gnat, had already been discovered—although I was not aware of the fact. That function is to secrete the fluid which is injected by the insect when it punctures the skin—the fluid which causes the well-known irritation of the puncture, and which is probably meant to prevent either the contraction of the torn capillaries or the coagulation of the ingested blood. The position of the blasts in the cells of this gland could have only one interpretation—wonderful as that interpretation is. The blasts must evidently pass down the ducts of the salivary gland into the wound made by the proboscis of the insect, and thus causes infection in a fresh vertebrate host, a fact which could fortunately be proved without any difficulty by observations on the parasites of birds.

It was most interesting to watch the gradual development of the parasitic invasion in birds; and this development presented such constant characters that, apart from other reasons, it was quite impossible to doubt that the infection was really caused by the mosquitoes. The course of events was always as follows: The blood would remain entirely free from parasites for four, five, six or even seven days. Next day one, or perhaps two parasites would be found in a whole specimen. The following day it was invariably observed that the number of the organisms had largely increased; and this increase continued until in a few days immense numbers were present—so that, finally, I often observed as many as seven distinct parasites contained within a single corpuscle! Later on, many of the birds died; and their organs were then found to be loaded with the characteristic melanin of malarial fever.

These experiments completed the original and fundamental observations on the life history of the hæmamebids in mosquitoes. The parasites had been carried from the vertebrate host into the gnat; had been followed in their development in the gnat; and had finally been carried back from the gnat to the vertebrate host. The theories of King, Laveran, Koch and Bignami, and the great induction of Manson, were justified by the event; and I have given a detailed historical and critical account of these theories, and of my own difficulties and experiences, in the hope of bringing conviction to those

who might, perhaps, otherwise think the story to be too wonderful for credence.

I shall first try to indicate how completely recent discoveries explain the well-known laws regarding the diffusion of malaria. As mentioned at the beginning of this lecture, malarial fever has long been known to be connected with the presence of stagnant water. That is to say, we generally, though not invariably, find that the disease is associated with low lying flat areas, where water tends to collect to a considerable extent. It was, indeed, the general appreciation of this law which led to the old miasma theory of the disease—the theory on which the word “malaria” was based. We assumed that the poison is one which rises from marshy areas in the form of a mist, and which thence infects all living within a given distance. Later, when the pathogenetic parasite was discovered in the blood of febriculous, many observers, still clinging to this conception, thought that the parasite is an organism which in its free state dwells in such places, and diffuses itself in such mists. It is interesting to note how near to the truth this almost instinctive conception took us. It is right in idea, wrong in fact. It is not the parasite itself which springs from the marshy ground, but the carrier of the parasite.

This was one of the many interesting points made by King in his mosquito-theory of 17 years ago. But King fell into an error which could have been used as a powerful argument against his hypothesis. He seemed to have assumed that all mosquitoes rise from marshes. Hence, he said, malaria exists in the presence of marshes; hence it is a disease of the country, rather than of towns, and so on. As a matter of fact, mosquitoes as a rule do not rise from marshes at all; they do not all even rise from pools of water on the ground; the commonest species, at least of those which habitually annoy human beings, spring from tubs and pots of water in the vicinity of houses, and are indeed more common in cities than in country places, at any rate in the Tropics. Now it is not the least interesting feature of recent researches that they have shown where the error lay. As soon as I have succeeded in cultivating the human parasites in my “dappled-winged mosquitoes,” which were really gnats of the genus *Anopheles*, I began to study the habits of these insects, and soon ascertained the remarkable fact that while gnats of genus *Culex* generally breed, in India, in vessels of water round houses, gnats of genus *Anopheles*, which I had just connected with malaria, breed in small pools of water on the ground. This point was made the subject of a special investigation by the recent expedition to Sierra Leone; and we found that the law holds good there as in India. While *Culex* larvae were to be seen in almost every vessel of water, or empty gourd or flower-pot in which a little rain-water collected, in only one case did we find *Anopheles* larvae in such. On the other hand, *Anopheles* larvae occurred in about a hundred small puddles scattered through the city of Freetown—puddles mostly of a fairly permanent description, kept filled by the rain, and not liable to scouring out during heavy showers. What was almost equally significant, the larvae seemed to live chiefly on green water-weed. Hence it follows that while *Culex*, the apparently innocuous genus of gnats, are essentially, or at least often, domestic insects, *Anopheles*, the malaria-bearing genus, are essentially gnats which spring from stagnant water on the ground. And numerous other facts in the history of malaria can be explained by the same discovery. It is supposed, for instance, that malaria originates from freshly-turned earth; now we actually noted examples where railway embankments and the like had produced *Anopheles* pools; and it is easy to see that disturbance of the soil may often produce depressions in the ground capable of holding a little rain-water suitable for the larvae of these insects. Again malarial fever often appears on board vessels which have touched at malarious ports; as an explanation of this we ascertained that *Anopheles* visits ships from the shore. In short, on studying the matter from every point of view, I must confess to being ignorant of any well-established fact about malarial fever which is not explained by the mosquito-theory.

This brings me to the subject of objections to the mosquito-theory. In view of the exact and copious microscopical and experimental evidence which has now been collected in proof of the theory, it is no longer permissible to doubt the main facts; and the objections which one still finds, both in the lay and the medical press, are generally based on a complete ignorance of these facts, and need not be discussed here. But there is one objection frequently made, in spite of corrections as frequent, by persons who reside in malarious places—which deserves comment. This is, that malaria exists where there are no mosquitoes, and that so-and-so has had fever without being bitten by gnats at all. Generally speaking, we must always remember that malarial fever is a disease in which relapses occur perhaps for years after the first infection, and that it is this first infection, and not the relapses, which are due to the bite of *Anopheles*. It is thus possible to suffer from any number of attacks of fever without being bitten by *Anopheles* (except on one occasion), and without invalidating the theory—a fact of which those who argue in this manner are generally ignorant. Again, it is well known that one may be bitten without perceiving it; that some persons are singularly callous to the punctures of these insects; and lastly, that many others have very limited powers of observation. I may say at once that, personally, I cannot accept any statement to the effect that gnats are absent in any locality in the Tropics, until such a statement is made by a competent observer after direct search; because I have never been in any place in the Tropics—and I have been in a large number—where there were no gnats. On the other hand, I have often found numerous gnats in localities where I was previously told there were none. I was once actually informed that there are no mosquitoes in Sierra Leone! The fact is, that those who will trust the statements of the general public on such matters must be very credulous.

I turn lastly to the all-important subject of prevention, but can do no more than touch upon it here. Two methods suggested themselves at once. I need not refer to that of guarding against the bites of these insects by the use of mosquito-nets and so on—an obvious and, I believe, an exceedingly useful measure, which may reduce the chances of infection to a small fraction. Unfortunately such methods will never be employed on a large scale in the majority of malarious localities; and we must resort to the destruction of malaria-bearing species of gnats. Early in 1892 I reported to the Government of India that it may be possible to exterminate *Anopheles* in some localities—especially some towns, cantonments and plantations—owing to the habit the insects have (in some places) of breeding only in selected pools. Since then, a considerable literature has already grown up round the subject. Reviewing this literature, it seems probable that we may be able to exterminate *Anopheles* or at least largely reduce their numbers, in towns where, owing to the conformation of the ground, the low level of the sub-soil water or the small rainfall, surface pools suitable for the insects are comparatively few. The methods which can be adopted against the larvae are numerous—such as brushing out the pools with a broom, draining them away, filling them up, or treating them with various culicides, such as paraffin and numerous other substances (recently investigated by Celli and Casagrandi). On the whole, the most promising method which suggests itself is the employment of some cheap solid material or powder which dissolves slowly, which kills the larvae without injuring higher animals, and which renders small pools uninhabitable for the larvae for some months. If, for instance, a cartload of such a material would suffice to extirpate the larvae for a square mile of a malarious town, the result would be a large gain to its healthiness. Dr. Fielding-Ould has lately reported favourably on tar. Grillet recently reports a case in France where a large district was rendered free of malaria by the extensive use of lime for agricultural purposes. Gas-lime, or even common salt, may be suggested. In short, though the question of the possibility of attacking these insects with success is still entirely in the experi-

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4. Are the clinical results from hydrotherapy sufficiently well established? Among acute diseases the results of hydrotherapy are so satisfactory that no physician does justice to himself or his clientele in neglecting its study and practice. In typhoid fever, scarlatina, measles, pneumonia, we have the testimony of Ziemssen, Juergensen, Liebermeister, Traube, Furbringer, Nothnagel, Delafield, Osler, Peabody, and others, to the effect that many lives may be saved by a judicious application of water externally and internally. In typhoid fever alone its results are marvellous. This is not the *ex parte* statement of an enthusiast. It has the support of the only exact statistics in medicine. Dr. A. Vogl, Medical Director at Munich, has published the records of 8,325 cases of typhoid fever observed in his military hospitals during forty-seven years, giving details of peculiarities of each epidemic, treatment, and autopsy findings and other data, showing a reduction of mortality from 20 per cent. under various treatments in vogue in the different epidemics to 2.7 per cent. That intestinal perforation, tympanitis and diarrhoea have been greatly reduced by the Brand bath, early begun, is evident from these statistics, which are the most trustworthy ever published because they are obtained from persons of the same sex, almost the same age, the same occupation, diet, and environment. Dr. Hare, of the Brisbane Hospital, although not always practising the exact Brand method, reports excellent results (*Practitioner*, 1897.) Dr. Cayley (a) made an eloquent plea for the cold bath in typhoid, concluding, "We have here a potent weapon, originally, indeed, forged in this country by a skilful artificer, but which again sharpened and polished by the great physician of Stettin, has been restored to our hands, and by whose aid we may succeed in saving a considerable proportion of the 8,000 victims now sacrificed." Unhappily this able clinician's plea has borne but little fruit. (See introductory remarks.)

The method of continuous baths practised so successfully by Barr, of Liverpool, is also an evidence of the value and flexibility of hydrotherapy. This kind of baths was originally introduced by Riess of Berlin, who reports several hundred cases in the *Berliner Klin. Wochenschrift*, 1888-1889.

May I not say without presumption that the bath treatment is worthy of investigation and imitation in Great Britain?

In my personal observation there has been no very great difficulty in applying it in private or hospital practice, and herein I am corroborated by Ball, Gilman, Thompson and Peabody of New York, Osler of Baltimore, J. C. Wilson and Tyson of Philadelphia, and others. Recent text-books on hydrotherapy contain directions for substitutes for the Brand baths which seem less heroic, and may be useful to those who have not the courage of conviction by previous experience.

In pneumonia (*Medical News*, 1896), I have reported the results of observations in the Hood-Wright Hospital, in which the mortality during the past eight years has been reduced to one-third its former rate, since my colleagues have adopted the following simple mode of management. The patient is treated and not the disease, by enhancing his resisting powers to the latter. He receives a large dose of calomel, after which no more medicine is given unless hypodermics of morphia for excessive pain, or the same of strychnia be required for heart failure, which in private practice, when cases are seen early, is rarely the case. Patient receives 6 ozs. milk and 6 ozs. cold water alternately every two hours. A compress of three folds of old linen, wrung more or less according to body temperature out of water at 60°, is wrapped singly around the chest and covered

by one layer of flannel, every half-hour or every hour, according to temperature, ceasing when the latter reaches 100°. Under this treatment the heart is braced, respiration deepened, sensorium relieved, excretion increased (I have seen 122 ozs. urine in one case, and often, as in typhoid fever, 60, 70, or 80 ozs. every 24 hours). In insolation a great improvement has been made by applying correct hydrotherapeutic principles, abolishing the antithermic treatment by very cold baths and ice packs, which gave in the New York epidemic of 1896 a mortality of 30 per cent. The method of sprinkling with ordinary cold water 70°, or by effusion from basins, or ablution with cloths, *i.e.*, combining mechanical stimulation to the cutaneous vessels, and thereby removing the check of heat diffusion, which is causing heat retention, has been most successful, reducing the mortality to 7 per cent. (Baruch on Hydrotherapy, *Ibid.*).

In cholera infantum, cholera Asiatica, acute rheumatism, with or without hyper-pyrexia (see Robertson, *Edinburgh Med. Journal*, 1897) I have observed the most surprising results in desperate cases (*Ibid.*). The results in all acute diseases are far better, if this treatment is not reserved for advanced cases.

In chronic diseases in which hæmatosis and nutrition are usually in abeyance, most satisfactory changes may be obtained by a judicious application of hydrotherapeutic procedures.

In conclusion, I beg to offer the following epitome of my own observations. In a paper read before the New York State Medical Society, in 1892, I ventured to state that "in many chronic diseases it has proved so successful after failure of medicinal agents that no case should be yielded up as hopeless until hydrotherapy in some form has been tried." Eight years have elapsed since this statement was made, and it may be conscientiously reiterated to-day by reason of my observation in numerous cases which have been referred to me by colleagues after disappointment with the best therapeutic methods.

A type of cases which I see quite often is that trying class of neurasthenics which wander from one doctor to another, and sooner or later become the prey of charlatans and Christian science faddists. These patients present every phase of depreciated vascular and nerve condition. They look wan and worn from loss of appetite and sleep, digestion is impaired, introspection renders them and all around them miserable. Such a case has probably once been benefited by treatment, rest-cure, change of air and scene; but he returns to his unfavourable environment, and gradually but surely all his old symptoms return. He again finds himself tottering on the brink of invalidism; now he believes his reason threatened, his memory weakened; he is the prey of morbid fears, he becomes the despair of family, friends, and physician. What prospect is there for such a case? I can say from actual observation, that if such a patient be subjected to a methodical course of hydrotherapy the result will prove a revelation, provided there be no organic basis for the malady. Mild procedures may not meet all the indications of this type of cases, although they may be useful as an introduction to more positive treatment. Douches adapted with regard to temperature, duration, and pressure to each individual case play the most important rôle here. These are capable of arousing the dormant neurons, enhancing vascular activity, and improving general and local nutrition. The cortical centres, which are the chief points of failure in these depressed neurasthenics, feel the impulse of a better circulation and nutrition. The morbid ideas and illusions vanish. The hypochondriacal introspection ceases, and the patient slowly but surely regains his neuro-vascular equilibrium. The results of hydrotherapy in such cases are far more endur-

ing than those following other methods, in my experience.

Another set of cases which are greatly benefited by hydrotherapy are those unsatisfactory rheumatic, gouty, and lithæmic conditions which are the bane of the doctor's life, and which we are so often glad to rid ourselves of by sending them to the hot springs. At these resorts many remarkable cures are effected by removal of the patient from unfavourable environment, and by the judicious application of baths and douches under the direction of their skilful physicians. Unhappily, few of our patients are able to leave their homes for this purpose, and for these much may be done by methodical hydrotherapy at home. The course adopted at these springs may be usefully imitated wherever douches under pressure of 20 to 30 lbs. can be had. This treatment stimulates the emunctories, especially when it is combined with the abundant and methodical drinking of water. Products of retrograde tissue change are eliminated, normal products are formed. Although the patient may lose flesh, his appetite, sleep, and general comfort are increased, and if the dietary and mode of life are properly regulated his health may be entirely restored. While we cannot approach the rapid and decided effects attained by our colleagues at the hot springs, to whom such cases should preferably be referred, great relief may be afforded and even complete restoration may be slowly attained by the hot douche and bath treatment at home.

If there be medicinal agents which are capable of producing similar effects, I have failed to discover them during an active professional life of 37 years. Far be it from me to depreciate the Pharmacopœia, but I have arrived at the stage of which that wise therapist, the late Alfred Loomis, once said in the Academy of Medicine: "Physicians prescribe less medicines as they grow older."

My personal experience with hydrotherapy in chronic diseases extends over a period of 10 years and embraces over 100,000 recorded procedures in neurasthenia, hysteria, some of the psychoses, phthisis, gout, rheumatism, dyspepsia, cardiac diseases, sciatica and other neuralgias, obesity, and neuritis (in private practice and in the hydriatric department of the Riverside Association, which receives patients from the Vanderbilt Clinic, the Mount Sinai, and other dispensaries). The application of this method of treatment to such varied diseased conditions is rendered possible by its flexible nature, which enables us to adapt it by modifications of temperature, pressure, and duration, and numerous technical details to the most varied pathological manifestations, provided the physician has mastered its *rationale* and mode of action, and its details are not left to the judgment of bath-nurses.

My confidence in the value of hydrotherapy in chronic diseases borne out by actual clinical observation, is confirmed by the most noted clinicians of the present day, as I have shown.

It is evident from the preceding facts and cases that, if water is to occupy a lasting position among remedial agents, a place from which the whims and fancies, the prejudices and passions of coming generations shall not again displace it, it must remain in the hands of medical men entirely, its theory and technique must be taught in our schools, and its application demonstrated in our hospitals. The latter is now done in some of the best medical schools of Europe. In Vienna, Professor Winternitz has a clinic and delivers a regular course of lectures on hydrotherapy. In Heidelberg, Professor Vierordt has also established a hydrotherapeutic clinic. In the Berlin University Clinic, Professor Leyden also dwells upon hydrotherapy with much emphasis. The great teacher Kussmaul has recently pointed out the crying need of instruction in this branch

of therapeutics. Agitation in favour of making it a regular subject for instruction in the universities has also been begun in the German Parliament. Only by this means will water be rescued from the hands of the quacks and empirics, who thrive upon it, to the detriment of the educated practitioner. Witness the crowds of people who fifty years ago flocked to Graefenberg from all parts of the world, to be treated with water by the ignorant peasant Priessnitz. Very recently history has repeated itself in the great fame attained by a priest, Father Kneipp, who successfully imitated Priessnitz in the enormous congregation of sick people whom his water-cures attracted to Woerishoefen,

Such incidents must lower the medical profession in the estimation of people whose faith in medical learning and skill is rudely shaken by the cures accomplished by a layman after failure of the physician. Is it not clear that if these lay people, who know nothing of the *rationale* of water, and who practice hydrotherapy in the most mechanical fashion, can accomplish so much, the educated physician must achieve far greater results if he has been properly instructed in the technique and *rationale* of hydrotherapy?

The writer trusts that the forgoing *résumé* will convince the reader that the remedial application of water has been unjustly neglected, that it fulfils every demand of a therapeutic agent, and that it appeals not alone to specialists but also to the hard-working family doctor as a simple, rational, flexible and always obtainable remedy in typhoid and other fevers, the exanthemata, rheumatism, gout, the various neuralgias and other diseases with defective hæmatisation, nutrition, or tissue change.

Clinical Records.

EXCISION IN RECURRENT DISLOCATION OF THE SHOULDER.

By A. STANLEY BARLING,

Hon. Surgeon Royal Lancaster Infirmary; Surgeon to H.M. Prison, Lancaster Castle.

CASES in which dislocation of the shoulder has recurred so frequently as to call for operative interference are not common; those in which excision has been done appear to be rare. Hence the following may not altogether lack interest.

J. B., æt. 26, was sent to me in May, 1897, by Dr. Todd. He stated that six years before, in India, he had a struggle with a violent prisoner whom he was removing to the guard-room. They both fell, and B. was found to have suffered a dislocation of the right shoulder. This was reduced without difficulty, but unfortunately it soon began, with equal ease, to be reproduced. As the patient said, "it was always slipping out, I dislocated it 57 times in five years."

In consequence of this the man was invalided out of the army. On his return home he resumed his former work as labourer in an oilcloth manufactory. He found, however, that he was quite unable to continue, as his arm gave way almost at once. His condition was this. For a day or two he would work without mishap, then the dislocation would occur and he would be off work for a week or so. This rendered him incapable of earning his living.

On examination of the shoulder, nothing abnormal could be found except that when he relaxed the muscles of the joint the bones seemed very mobile.

I thought that it might be possible to do good by cutting down on the joint. There might be a rent in

the capsule which could be sutured, or a fracture of the edge of the glenoid cavity which could be repaired. Failing these, there was always excision to fall back upon. The matter was explained to the patient, and he readily gave his consent. On having it put to him, he said that even a stiff shoulder would be of more use to him than one on which he could never rely for a moment. The patient was accordingly admitted into the Royal Infirmary on May 11th and put under ether. A subcoracoid dislocation of the humerus could then be readily produced. The joint was exposed by the anterior incision. There was no fracture, and no rent in the capsule, but the latter was very large and baggy, allowing the head of the humerus to pass completely out of its socket, either downwards or inwards. The capsule was laid open, and a large oval piece excised from the front of it. On stitching this up, however, I found that it produced no good effect, the bone becoming luxated as easily as before. I accordingly removed the head of the humerus, sawing through its anatomical neck. The edges of the capsule and the skin wound were united with stout catgut sutures. Healing took place by first intention. Passive motion was not begun for a month as it was of more importance to obtain good false ligaments than to aim at getting a very movable joint. The man returned to work three months after the operation. I saw him last a few weeks ago. He said that he had followed his employment continuously for nearly three years and had had no trouble. There was fair movement, in the joint. The man could put his hand on the back of his neck.

Transactions of Societies.

ROYAL ACADEMY OF MEDICINE IN IRELAND

SECTION OF STATE MEDICINE.

MEETING HELD FRIDAY, APRIL 27TH, 1900.

The President, Sir C. A. CAMERON, M.D., in the Chair.

ASYLUM PATHOLOGY.

DR. W. B. DAWSON read a paper on this subject, an abstract whereof will be found on page 620.

In the discussion which ensued, Dr. NINIAN FALKNER suggested that something might be accomplished if the Section sent up a petition to the Council to memorialise responsible bodies on the subject.

Dr. CONOLLY NORMAN remarked that the London County Council had formed a commission which had instituted a number of minute inquiries on the subject, and had issued several volumes of evidence which tended to prove that their methods for the cure of insanity lagged behind those of medicine in general.

Sir C. CAMERON spoke in favour of a pathological laboratory such as suggested. He was surprised at the small cost which Dr. Dawson thought it could be kept up at. He remembered seeing in "Tidy's Chemistry" a curious statement that in the brains of idiots there was a smaller amount of cerebro-phosphorus than in the sane, whereas in the insane there was a greater amount. It would follow from this that they should withhold phosphoric food from the insane, and be more liberal with it in the case of the idiotic. In a pathological institute they might ascertain many facts of that kind which might have an important bearing on the treatment of the insane.

Proposed by Dr. NINIAN FALKNER and seconded by Dr. MARTLEY:—

"That the project of establishing a Central Laboratory in connection with the Irish Lunatic Asylums for the study of the pathology of nervous and mental disease is deserving of the support of the Royal Academy of Medicine in Ireland, and that the General Council be asked to communicate with asylum boards throughout Ireland on the subject."

THE MEDICO-LEGAL RELATIONS OF GENERAL PARALYSIS

Dr. CONOLLY NORMAN read a paper on the medico-legal relations of general paralysis. He said that it is natural that the great cerebral disease which forms in itself an epitome of all mental affections should often bring its victims into conflict with the law. But besides the general tendency of all mental disease to cause misadjustment with the social environment, often expressing itself in the form of "crime," there appeared to the speaker to be certain special features in the criminality of the general paralytic which made him of particular interest to the medical jurist. Dr. Norman proceeded to consider the general paralytic's offences under three heads:—(1) Violence, of a peculiar brutish and irrational character. (2) Sexual impropriety, depending, no doubt, in part upon the lack of judgment, which is the essential feature of the malady, and partly upon the sexual irritability common in its earlier stages. (3) Theft. A number of cases were detailed, exemplifying each form, and some illustrating all. With regard to theft, the speaker pointed out that the common notion is quite erroneous—namely, that the thefts of the general paralytic are always *volés à l'étalage*, and characterised by silliness and absence of purpose. On the contrary, in certain cases which he mentioned, fraudulent acts of considerable subtlety had been the earliest overt symptoms of general paralysis.

Dr. DAWSON asked if he rightly understood that the attacks of violence resembled the congestive attacks of epilepsy. With reference to the sexual impropriety, the point of interest was that victims of locomotor ataxia were frequently affected in the same way at the beginning of the disease, though, of course, later on they lost sexual power altogether.

Dr. DOYLE spoke about syphilis as an antecedent to general paralysis. A tremulous mode of articulation was often observed long before the disease appeared, and he knew of one case in which a noted speaker, the father of a general paralytic, evinced this peculiar tremulous speech.

Dr. MARTLEY said he knew personally a young man who was highly intellectual, a brilliant chess-player, and the first sign of the disease that he gave was an uncontrollable attack of violence.

Sir C. CAMERON said that in a case that came under his notice the first evidence of his being *non compos mentis* was his non-appearance to give a lecture in Brighton for which he had made great preparations. He had totally forgotten about his intention to lecture that night. It turned out to be a case of general paralysis, and he subsequently died in Swift's Hospital. This bore out the remark that forgetfulness was often one of the earliest symptoms, and its sudden onset was evinced in this case.

Dr. CONOLLY NORMAN, in reply, said he meant to convey that the violence was the same kind of unreasoning, intense, and uncontrolled violence as they saw in an epileptic, but he did not associate it with the epileptic phenomena. He had never met a case exactly like Sir C. Cameron had mentioned—namely, commencing with a sudden attack of amnesia.

The Section then adjourned.

NORTH OF ENGLAND OBSTETRICAL AND GYNÆCOLOGICAL SOCIETY.

MEETING HELD MAY 18TH, 1900 (at the Medical School, Leopold Street, Sheffield).

The President, Dr. HELLIER, in the Chair.

Dr. H. BRIGGS (Liverpool) showed numerous specimens and water-colour drawings, illustrating the various types of fungus or villous endometritis, benign and malignant adenoma of the uterus. He alluded more particularly to the difficulty of deciding upon the microscopic evidence between inflammatory conditions of the endometrium and malignant adenomatous disease of the uterine glands, and quoted several illustrative cases. Remarks were made by Drs. Donald and Martin.

Dr. A. DONALD (Manchester) showed a uterus with multiple fibroids and containing a foetus of 4½ months' development. Several of the tumours were situated in the pelvis below the fetal sac and would have obstructed labour. The whole mass was successfully removed by abdominal hysterectomy.

The PRESIDENT showed a large dermoid cyst with a twisted pedicle successfully removed by abdominal section.

Dr. ARNOLD W. W. LEA (Manchester) read a paper entitled,

THE INFLUENCE OF GONORRHOEA ON THE PUERPERIUM, WITH NOTES OF FIFTY CASES.

The diagnosis of gonorrhoea at the time of delivery was based upon the occurrence of ophthalmia neonatorum in the infant within three days of delivery, combined with the clinical history of the cases. The puerperium was normal in 60 per cent. of the cases, as judged by the absence of pyrexia. In four of these, however, at the fourteenth day there was evidence of pelvic inflammation. In two cases parametritis with swelling in the region of the appendages; in two cases parametritic exudation was present. In 40 per cent. of the cases the puerperium was abnormal, accompanied by pyrexia, and associated with symptoms of local infection of the genital tract. The rise of temperature usually commenced on the third or fourth day after delivery, and was accompanied by a purulent discharge from the uterine cavity. In many of the cases the infection remained limited to the uterus, but in five instances (10 per cent. of the total number) acute pelvic peritonitis ensued, with an illness lasting some weeks. Details were also given of three cases in which a previously-existing gonorrhoeal infection of the appendages became virulent during or immediately after labour, each case terminating fatally. From a study of these cases, and a review of the literature of the subject, the following conclusions were drawn:—

1. The presence of a purulent vaginal discharge during labour which is capable of causing ophthalmia neonatorum renders the patient liable to puerperal infection.
2. The infection is in many cases a mixed one, the gonococci being associated with streptococci and staphylococci, although the gonococcus itself is capable of causing severe infection, and may be obtained in pure culture from the uterine cavity (Kronig-Bumm).
3. Lacerations of the perineum, vagina or cervix, forceps deliveries and prolonged labour greatly increase the liability to infection.
4. The types of disease may be (1) purulent endometritis; (2) acute pelvic peritonitis; (3) parametritis; (4) septicæmia (rare).
5. In some cases an old infection of the appendages may light up during labour or after delivery, leading to acute peritonitis, which may be fatal.
6. The prognosis as to life is usually good, though recovery is often imperfect.
7. The treatment by vaginal douches after delivery is insufficient in many cases to prevent infection of the endometrium, and may be the cause of infection.
8. If infection of the uterus occurs, uterine douches should be given daily, the patient maintained at absolute rest, and a careful watch kept for evidence of localised pelvic peritonitis. In some cases, if douches fail, exploration and curettage may be required.

NEW CLINICAL LABORATORIES AT THE WESTMINSTER HOSPITAL.

The clinical laboratories which have been added to the equipment of the Westminster Hospital were opened on Tuesday, the 12th inst., by Lord Lister, President of the Royal Society, in the presence of a large and distinguished company of medical and scientific men. The need for these laboratories has long been felt in order to facilitate a more scientific and systematic examination of disease than can be carried out satisfactorily in the wards. They are equipped with the latest apparatus, so that in future the most recent microscopical, chemical, and bacteriological methods will be applied in the diagnosis of the diseases from which the hospital patients are suffering. The establishment of clinical laboratories, it is hardly necessary to point out, in virtue of the facilities they provide for correct diagnosis and

more precise treatment, is a step which cannot fail to increase the efficiency of the hospital as a means whereby real benefits are made available for the sick poor. Acting on this belief, the hospital authorities have drawn heavily upon their capital in order to make the laboratories thoroughly efficient, and they confidently look to the public to see that their expenditure on this improve-



LORD LISTER.

ment does not impair the efficiency of the hospital in other directions. The opening of the laboratories was preceded by a reception in the board-room of the hospital held by Sir J. Wolfe-Barry, chairman of the House Committee, Dr. Allchin, senior physician, and Dr. Lazarus-Barlow, pathologist to the hospital. The company included, beside Lord Lister, Lord Kelvin, Viscount Knutsford (a vice-president of the hospital), the Dean of Westminster, Sir W. MacCormac (president of the Royal College of Surgeons), Dr. Church (president of the Royal College of Physicians), Sir Dyce Duckworth, Sir Squire Bancroft, and Mr. J. G. Talbot, M.P.

Sir J. Wolfe-Barry, on behalf of the House Committee, remarked that Westminster Hospital was one of the oldest hospitals in London, having been founded in 1719.

SIR JOHN WOLFE-BARRY, K.C.B.
Chairman of the House Committee.

He pointed out that the main purpose of the clinical laboratories was the elucidation of disease in the hospital, and, to that extent, they would be beneficial to the poor. They were not for independent research, but the benefit to the hospital patients from the researches which would be carried out would extend to all classes. For the present, at any rate, they had not thought it desirable to apply for a licence to make experiments on animals. In time they hoped to institute an electrical laboratory fitted with the apparatus for the Röntgen-rays and micro-photography. To meet these expenses £10,000 was wanted.

Dr. Lazarus-Barlow described the disposition of the

laboratories, which, he remarked, contained all the most recent apparatus for the clinical work of the hospital.

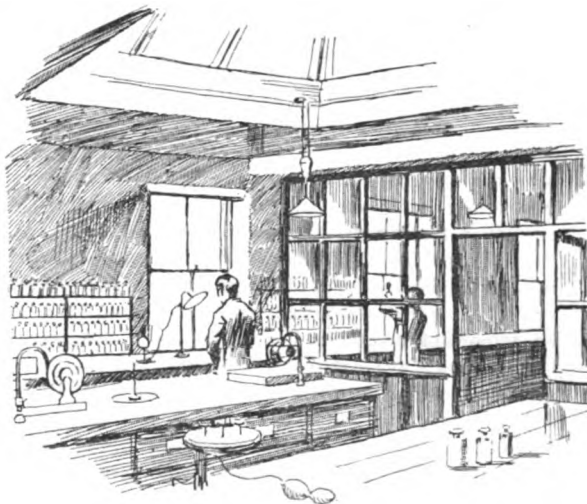
The company then visited the laboratories, which are on the top floor of the hospital, where the opening cere-



DR. LAZARUS BARLOW.

mony was formally gone through by Lord Lister, assisted by Lord Kelvin, which consisted in their each starting separate parts of the apparatus. On re-assembling in the board-room,

Lord Lister said it was no less a pleasure than an honour to him to take part in that day's ceremony. The beautiful clinical laboratories they had inspected would give the physicians of the hospital an opportunity of bringing to bear on their cases the most advanced knowledge and the most refined methods of investiga-



tion. Many a diagnosis which would otherwise be obscure would be rendered clear in those rooms. He need hardly say that the correct diagnosis was directly proportioned to successful treatment. In respect of what Sir J. Wolfe-Barry had said he himself felt convinced that those who had worked in the laboratories would not only benefit patients in the hospital, but would also, unfailingly, be able to extend the boundaries of knowledge and promote the now rapid advance of pathological and therapeutic knowledge. The laboratories would also be of service as a powerful means of affording sound practical knowledge to the student. No doubt there was nowadays a tendency to look somewhat askance at medical schools in connection with hospitals, and to grudge the money for their maintenance and extension. There could not possibly be a greater mistake. Without the opportunity of practical instruction afforded by hospitals, the education of the rising generation of medical men would be absolutely impossible, and it might be fairly discussed whether the educational services rendered by hospitals were not of greater importance to the welfare of the community than their direct advantages to the patients treated in them.

He considered that the public owed a debt of gratitude to the governing body of Westminster Hospital that they had wisely and boldly devoted a large sum of money to the creation of these laboratories. He felt sure that, before many years were over, it would be recognised that those laboratories were among the most important means of doing good service to the community which hospitals could contain.

Dr. Church, in the course of his remarks, insisted on the fact that facilities for the investigation of disease were much more important than filling hospital beds.

Sir W. MacCormac recalled that five years ago similar laboratories were created at St. Thomas's Hospital, and great advantage had accrued from them. Accuracy of diagnosis, which they tended to increase, facilitated certainty and success of treatment, and such an acquisition as the new laboratories was one upon which Westminster Hospital might be warmly congratulated.

On the motion of Lord Knutsford, seconded by Dr. Allchin on behalf of the medical, and by Mr. Spencer on behalf of the surgical, staff, a vote of thanks was passed to Lord Lister for opening the laboratories.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, June 16th, 1900.

At the Surgical Congress, Professor Olshausen read a paper on

CONSERVATIVE SURGICAL TREATMENT OF UTERINE MYOMATA.

He considered it necessary for the surgeon to limit his operation as much as possible, and especially to remove no parts of the organism, the taking away of which was not absolutely necessary. This limit was not always adhered to. When the uterus was extirpated surgeons thought the ovaries were of no further use. The removal of normal ovaries was not an indifferent operation, for the consequences of such removal were very disagreeable. Removal of the uterus gave no sign of its loss, but this was not the case with the ovaries when removed before the menopause. This was an important point for those who had the welfare of their patients at heart. It was not the cessation of the monthly flow that embittered the lives of many patients, but the loss of function of the ovaries. For this reason he had for a long time left the ovaries in cases of amputation of the uterus for myoma. The operation was rendered more difficult, but it was more advantageous to the patient. From similar consideration in myoma of the cervix he left the body of the uterus along with the ovaries. Some months ago a lady of thirty came under his treatment for profuse hæmorrhage. Examination showed just beyond the introitus a cervix enormously enlarged by a myoma larger than an ostrich egg. There was no tumour above the cervix. The speaker operated from the vagina, cutting the cervix across laterally, enucleated the tumour, and sutured the body of the uterus into the vaginal opening. The tumour weighed 1,250 grms. The patient was discharged on the twenty second day.

Simple enucleation was only justifiable in case of solitary myoma. Out of 207 operations for myoma during the last three years 29 enucleations had been performed with retention of the genital organs. This deserved more consideration on the part of operators. It was true he admitted that the radical operation had become far less dangerous, but carefully performed

enucleations were not dangerous. Lately he had enucleated where there were several myomata, and had left some small ones, i.e., in women over 40, when they would not grow. In younger women, also he operated conservatively when there was a possibility of their having children. After enucleation, the very irregular bed from which the myoma had been shelled out should be carefully sutured.

The speaker then turned to the question how far myomata in general required surgical interference. Some statistics gave the percentage at 42. He himself, who only operated when the symptoms were serious, had become more and more conservative as years went on and out of his last 320 cases he had only operated in 53, or in 16½ per cent. of the cases.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, June 16th, 1900.

CHRONIC MERCURIALISM.

At the "Gesellschaft der Aerzte" Erben exhibited a patient with exhaustion tremor movements in the voluntary muscles, which had continued for the last four months. Eighteen years ago mercury was administered, and was soon followed by attacks of a slight nature. In the intervals of treatment there is no tremor in the extremities, but as soon as the ointment is rubbed in the trembling commences. He admitted the difficulty in diagnosis, as many therapists affirm that it is not the drug that is the cause but the syphilitic virus operating on the nerve centres. Erben is inclined to believe that the mercury is the cause in the present case.

MEDULLARY CANCER OF UTERUS.

Latzko brought forward a female on whom he had operated for cancer at the neck of the uterus implicating one of the ureters. He removed the uterus *in toto*, excised the cancerous portion of the ureter, and attached the central section of the ureter to the mucous membrane of the bladder. She made a good recovery, and now appears in good health.

AN ACOUSTIC MICROPHONE.

Exner showed an instrument which he describes as a "Microphone" for acoustic observations. It is really divided into two parts, in fact, a micro-telephon. The microphone part is a sort of silk tube filled with charcoal powder and closed at both ends with a metal plate. To one of these tubes is attached the pole of a battery, which carries a metal point to be applied to any part of the ear to be tested. The plate at the opposite end of this microphon carries a primary coil connected with the opposite pole of the battery. A secondary coil is inserted in the current after the fashion of an ear telephone apparatus. If the metallic point be placed in the ear of a patient the vibrations will be transmitted from the point to the metallic plate, and thence to the carbon powder, where it meets with varying forms of resistance according to the arrangement of the particles; these vibrations are lastly transmitted to the secondary coil or induced current, and then to the telephone plate at the ear. He concluded his demonstration by announcing that he would place a few systematic experiments before them at a future meeting.

TEST FOR BLOOD IN URINE.

Strubell, at the Medical meeting, dilated largely on the "new method of testing for blood in the urine," which is simply a modification of Pulfrich's immersion-refractometer which hitherto has been viewed as a medical toy. Strubell has fixed a refraction exponent for different animal fluids that promises fair to make it a useful clinical instrument. Blood serum, sugar, &c., in urine can be detected by it with the greatest ease.

LOWIT'S HÆMAMØBÆ.

Turk gave his experience from repeated examinations of the blood in leucocythæmia, and endeavoured to prove that Lowit's "specific bodies" or parasites belonging to the group of the protozoa were not the exciting cause of leucocythæmia. He considered the "specific bodies" were the result of the cells breaking up when the granular matter of the cell along with the colouring matter adhered to from the specific mass. He, therefore, viewed the change as a result rather than a cause of the disease. He showed how typical hæmamœba could be obtained by physically washing the granular matter from the large cells. Lowit's argument of having transferred leucocythæmia to guinea pigs was not without objections, as this operation would produce blood changes in the different organs, thus producing a sort of recurring leucocythosis that would tend to form the same hæmamœba.

Lowit repelled Turk's inferences as illogical and erroneous. The presumed theory of large cell granulation accumulations is an old substitute which he very soon learned to distinguish as quite distinct from the hæmamœba to be met with in leucocythæmia. The masses of large cell granulations could be easily distinguished from the amœba, as the former never have the typical sickle or whip form.

Continental Notes.

[FROM OUR SPECIAL CORRESPONDENT.]

RONCEGNO.

IN reply to inquiries arising from the article in THE MEDICAL PRESS AND CIRCULAR of April 11th, 1900, upon this health resort of the Austrian Tyrol, I am glad to be enabled to give an analysis of the Roncegno Mineral Water, and some extracts from several medical reports, for the information of those who have sought it, and of your readers generally.

Analysis of the Arsenious-Ferrous Natural Mineral Water of Mount Tesobo, Roncegno. By Dr. Pietro Spica, Professor of Chemistry at Padua University.

	Grammes.
Sodic Chlorine (Na Cl)	0.00362
Sodic Arseniate (Na Ar O ₃)	0.10960
Sodic Sulphate (Na ₂ SO ₄)	0.07260
Potassic Sulphate K ₂ SO ₄)	0.05440
Magnesian Sulphate (Mg SO ₄)	0.47070
Calciferous Sulphate (Ca SO ₄)	1.84570
Sulphate of Cobalt (Co SO ₄)	0.02504
Sulphate of Nickel (Ni SO ₄)	0.04745
Sulphate of Manganese (Mn SO ₄)	0.21794
Sulphate of Alumina (Al ₂ (SO ₄) ₃)	1.38978
Sulphate of Copper (Cu SO ₄)	0.02891
Sulphate of Iron (Ferric Fe SO ₄)	0.08550

Sulphate of Iron (Ferric ox. Fe ₂ (SO ₄) ₂ O)	3.03750
Ferrous Phosphate (P ₂ Os Fe ₂)	0.03892
Salicylic Anhydride (Si O ₂)	0.12550
Arsenical Anhydride (As ₂ O ₃)	0.11588
Organic Matter	0.20950

Total per litre of water ... 7.87854

Dr. Spica says:—"The arsenical compounds explain the powerful action which the Roncegno Water exercises. Superior to all other arsenical waters yet analysed."

Professor Dr. Moritz Benedict (Division for Nervous Diseases, General Polyclinic, Vienna), writes:—"The Roncegno Water contributes not only to making blood, but also acts energetically on weakened or over-excited nerves. The advantage of being able by its use to obtain a positive action with relatively small quantities of arsenic and iron in combination, is in itself a great resource. Both internally and by baths it acts efficaciously in all cases of nervous and skin diseases."

Dr. Ernst Finger (Vienna) says:—"I have used always to my great satisfaction, Roncegno Mineral Water in chronic blennorrhœa, nervousness, mercurial sequences, and in all other diseases requiring arsenical cure."

Professor Dr. Pietro Gamberini (Bologna) states:—"My long use of the Roncegno Water, both in the Bologna Clinic Hospital and in my private practice, has plainly proved to me the beneficial action in such diseases, as anæmia, hepatosplenic obstruction, fever, chronic scrofula, and wherever iron united with arsenic is of advantage."

Professor Dr. Gruber (Otoiatría University Clinic) writes:—"To patients suffering from ear-ache, whose general state indicated a course of mineral ferruginous waters, I have for years prescribed the Roncegno Water, invariably with successful results."

Professor Hr. Otto Kahler (University Medical Clinic, Vienna), says, "For some years, and always with great success, I have used Roncegno Mineral Water in chlorosis, anæmia, malaria, cachexy, pseudoleucæmia, &c."

Dr. Fredericci (Superintendent-Director, United Hospitals of St. Chiara, Pisa), "The Roncegno Water is all that can be desired in chloro anæmia and symptomatic anæmy arising from incipient tuberculosis or general emaciation."

Professor Dr. Antigone Roggi (Director Provincial Insane Asylum, Voghera) certifies, "Roncegno Water is most efficacious in the cure of Discrasic disease; and is amongst the most powerful reconstituting remedies which can be prescribed!"

The Paris Exhibition.

I.—HOSPITALS AND MEDICAL ADMINISTRATION.

AMPLE justification exists for the pride the French take in their latest Universal Exhibition. It is certainly unique for its magnitude, beauty of situation, harmony as a whole and artistic finish of detail. This fairy city by the riverside, with its miles of white palaces set down amidst lovely gardens satisfies one's love of beauty, of form and colour, while it stirs up the popular craving for the novel and the unexpected. Whether we take the Rue des Nations, the Invalides Esplanade and the Champ de Mars on the South side of the Seine, or the Elysées Gardens, the Quai de Billy and the Trocadero on the North bank wonders meet us on all sides, for there are endless buildings and nearly everyone is a work of art. But the keynote of this Exhibition is its thorough-

ness, and though a mushroom city of joy, it is also a place for serious study.

Unlike the majority of Continental exhibitions, the present Paris show is in excellent sanitary condition. Drainage has been well attended to, and the conveniences for the public are sufficiently numerous and of very good types. The same thoroughness is to be noticed in connection with the medical service, which is under the direction of Dr. Gilles de la Tourette. The chief establishment is on the Champ de Mars, where there is an office in telephonic communication with the Paris hospitals, a register recording every case of illness, and every accident occurring at the Exhibition. There are also a consultation room and an operating room. Above are the sleeping quarters of the medical internes on duty. There are four other *postes* of this description, one on the Esplanade des Invalides, one on the Champs Elysées, another in the Trocadero Gardens, and the fifth at Vincennes. The Trocadero and Champ de Mars posts are the most busy, for they are situated in those parts where there are most side shows with residents. For instance, in the Trocadero Gardens there is quite a large colony of mixed races, chiefly Asiatic and African, who dwell in the basements of the plaster palaces or in encampments. All these people and their quarters are kept under rigorous medical supervision, and, so far, the bill of health has been remarkably clean, the medical register having few other records besides those of accidents, which, however, are heavy. To supplement this medical and surgical service, ambulance posts are installed in many buildings, where first aid can be given before patients are transported to the Exhibition hospitals. There are also ambulances by the river side, with everything to restore the apparently drowned.

This reminds us that near the grand bridge of Alexander III. there is a coquettish little steamer flying the Red Cross of Geneva. She belongs to the Union des Femmes de France, and is a model of a floating military ambulance, intended to transport wounded from the front to base hospitals, or from the base hospitals home. The planning and fitting are smartly carried out. In the fore part of the ship are fifteen beds, and in the stern eleven. They are comfortable, and specially constructed so as to prevent undue shaking. Beds are also provided for the staff, and there are kitchens, an apothecary's cabin, and model surgery. The exhibit is completed by a fine display of appliances, and also a series of most instructive plans of sea-going ambulances, intended either for transporting invalided soldiers, or for acting as hospitals to fleets during warfare. This is, indeed, probably the only practical outcome of the Czar's famous Peace Conference.

The Union des Femmes Françaises has another interesting exhibit on the Quai d'Orsay, where they have a small field hospital, built in wood. The little room is crammed with service medical outfits, rolls of sterilised bandages in cases, and many appliances required in the field or in field hospitals. The society does good work in showing how transport for the wounded can be improvised. It must be mentioned that the society also renders service in time of peace, having a first aid depot in Paris, and organises special relief to remedy disasters. Next door to these good dames is the exhibit of the Société de Secours aux Blessés Militaires, which is very rich in field hospital appliances. The surgical cases, boxes containing dressings, kitchen utensils and invalid foods are exceedingly compact. An appliance for sterilising bandages, instruments, constructed on the système Vaillant, is shown, and seems very simple. Perhaps the most complete of this series is the exhibit of the Association des Dames Françaises. First in order we find a hospital bed, very comfortable in appearance, taking up small space, and easily cleaned. The bed, as well as the night table, washstand, &c., are in metal, with a hard and glassy enamel. For field hospital purposes special folding beds, with webbing mattresses, are shown, as well as stretchers, ambulances on wheels, &c. A fine carriage ambulance justly attracts attention. On the roof are stored extra shafts, cushions, hampers containing rations, medicines, and bandages, also appliances

for use in cases of fractures, crutches, &c., two basins and two jugs in enamelled metal, sponges, bed urinals, canvas buckets, cords, ladder, and a box of tools for repairing the carriage. On each side of the coachman's seat are lockers, containing (1) eight bottles filled with iodoform, corrosive sublimate, boracic acid, carbolic acid, ammonia, laudanum, perchloride of iron, aromatic vinegar, sterilised dressings, sheets of paper, and pencils; (2) bandages, cotton, pins, brushes, soap, napkins, hand lantern and matches, string, ten drinking vessels, spoons, five bottles each of wine, lime juice, concentrated coffee, powdered sugar, and extract of balm. Under the carriage at the back is another case in which there is (1) a wooden box containing a mirror and a wash-basin; (2) a receptacle for heating water, and (3) case containing surgical instruments. There is also provision for storing a large quantity of *boiled water*. The carriage is about ten feet long and about four wide, and is a trifle over three feet from the ground, with a slight slope forward. There is room for four patients on stretchers, which are slung in leather belts. If stretchers are not required, ten wounded can find seating room in the carriage. There is room for three people on the box seat. Over and above this, there are specimens of transportable pharmacies and cabinets for surgical dressings and surgical instruments. It is an instructive exhibition. In the large building devoted to the Army and Navy are further exhibits of service medical and surgical equipments.

One building which ought not to be missed is the Palais de la Ville de Paris, which contains a marvellous collection of exhibits explaining every branch of municipal work carried on in Paris. Apart from the complete exhibits of the chemical, bacteriological, and meteorological laboratories, the section devoted to the Assistance Publique is most interesting. Practically, all the city hospitals, asylums, refuges, orphanages, &c., are under the Assistance Publique, and in this building the Administration has gathered together many things demonstrating how its establishments are equipped and managed. The hospital furniture is admirable; one item is deserving of study. It is an isolation cubicle (of glass and iron) intended for diphtheritic patients in children's wards. It is a model of the new installation adopted at the Hôpital des Enfants Malades. Close beside this are the old-fashioned square hospital bed to accommodate four patients and the modern regulation iron bedstead. Incubators for the rearing of children are shown in different patterns. The walls of this section are covered with a wealth of plans, elevations, and photographs of hospitals in existence or in course of erection. It is a most instructive series. The system of isolated pavilions is now generally adopted, and a splendid example of this method is afforded by the plans for the Hôpital Michel Bizot, with its enormous extent of basements fitted up for administrative purposes. Medical officers will also find much to admire in the models and photographs of the sanitary services, which include the disinfecting stations, market inspection, sewerage and water supply. Excellent models of hospitals and sanatoria for industrial settlements are shown in the Palace of Congresses, where the various medical conferences are shortly to be held.

The Operating Theatres.

MIDDLESEX HOSPITAL.

EXPLORATORY LAPAROTOMY.—MR. ANDREW CLARK operated on a well-nourished, healthy-looking man, at about 40, who had been under observation in the hospital a fortnight, having been admitted on account of pain in the right iliac region, which had been recurring at intervals for some months, and had of late been so acute that it prevented the patient following his occupation, that of a gardener. The man stated that he had been treated on two occasions within

the last two years for appendicitis, and it was believed that he was suffering from a similar attack when the present severe pain commenced. An examination under an anæsthetic revealed no physical signs, and the possibility of kidney affection having been excluded, an exploratory operation, which it may be said was anxiously desired by the patient, was deemed advisable. An incision between four or five inches long was made over the right linea semilunaris, and the thick layer of fat, upwards of an inch, having been divided, the edge of the rectus was found and the peritoneal cavity opened. The edges of the wound were then held open, and numerous adhesions of the omentum to the abdominal wall were found; these were divided and the cæcum with the small intestine entering it was immediately seen. After some searching the appendix, which was contracted but otherwise apparently healthy, was discovered bound down to the cæcum. Under these circumstances it was deemed advisable to leave the appendix alone. All adhesions of the omentum having been easily separated, the wound was closed layer by layer. Mr. Clark said the case was one of considerable interest, particularly when taken in connection with two other cases on which he had operated within the last few days. In the present case the appendix was probably the original seat of the trouble, and had given rise to local inflammations which had caused the adhesions of the omentum and the tension which had probably given rise to the dragging pains which were so distressing to the patient. The appendix itself had, he thought, apparently been restored to its normal condition. In one of the other two cases the primary cause of trouble seemed to have been the mesenteric glands, although the patient's symptoms and physical signs all pointed to suppurating appendicitis; and in the second case there appeared to be acute suppuration in the region of the appendix, which, however, the operation showed to be not the fact. Mr. Clark remarked that a feature in the case just operated on that might be noted was the extreme collapse which followed the breaking down of the adhesions, a condition that was occasionally met with when the peritoneum is much manipulated.

ST. PETER'S HOSPITAL.

LITHOLAPAXY IN THE CASE OF A LARGE STONE IN A BOY.—Mr. SWINFORD EDWARDS operated on a boy, æt. 18, but who was ill-developed, and did not look more than 14. The patient had had urinary trouble apparently since his birth, having undergone some operations when only two years old, the nature of which was obscure. For the past few years he had suffered from all the ordinary symptoms of stone—great pain at and after micturition, dribbling, increased frequency in passing water, with hæmaturia and sudden stoppage in the stream at times. Mr. Edwards had seen the case the previous day in the out-patient department, where he sounded the boy, finding a large stone in the neck of the bladder. With one finger in rectum and a hand on the hypogastric region—in other words, by the bi-manual method of examination—the stone was very easily felt, and indeed appeared considerably larger than it ultimately turned out to be; this was probably owing to considerable hypertrophy of the bladder wall, which was contracted on the foreign body, thereby giving to the finger the sensation of a large tumour. When the

patient was under ether Mr. Edwards remarked that he had intended to do a supra-pubic lithotomy, and this for two reasons—first, on account of the size of the stone, and secondly, on account of the smallness of the genital organs of the patient; however, at the suggestion of one of his colleagues, he would insert a lithotrite and see if it were possible to crush. Accordingly a No. 12 fenestrated lithotrite was found to pass into the bladder after a meatotomy; the stone which was very hard and white, and apparently of the size of a large walnut, was ultimately crushed, and the entire *debris* evacuated. The only circumstance calling for special remark was the fact that the fragments tended to lodge in a sacculus or pouch on the right side of the bladder neck, which was presumably the pouch in which the stone originally laid. To facilitate the crushing of these fragments the operator had to get his house surgeon to lift the patient's pelvis and legs high off the table, at the same time giving the pelvis a shaking in order to throw back the fragments into the cavity of the bladder. The operation, which was a somewhat difficult one, took the best part of an hour. Mr. Edwards remarked that had he stuck to his original plan and done the supra-pubic lithotomy, he would not have felt himself to blame, indeed for the general surgeon and a man who had not had large experience in crushing he would say that it would have been the best course to pursue, for such an operator probably would never have been able to complete the crushing operation, and would then, after the waste of valuable time, have been obliged to resort to the supra-pubic operation. With regard to this case, as matters at present stood the boy he considered was in a far better condition than if he had been subjected to the supra-pubic operation, as now, if all went well, the patient would leave the hospital entirely cured of his trouble in a week or ten days' time, whereas after the other method convalescence would take at least a month.

The Medical Temperance Association.

THE annual meeting of this association was held on the 12th inst. at the Medical Examination Hall, Victoria Embankment, London, after a reception, by the president (Professor Sims Woodhead) and council, of medical and scientific delegates to the World's Temperance Congress, which was being held in the same building. The annual report was read by the honorary secretary, Dr. J. J. Ridge, and showed an increase both of members and student associates to 487 and 515 respectively. The report expressed the hope that as it had been conclusively demonstrated that men could do more, harder, and more continuous work without it than with alcohol, the rum ration should be abolished, and the canteen purged from intoxicating drinks. It was announced that a Manchester branch had been formed of which Dr. A. T. Wilkinson had been elected president, and Dr. Gray Clegg hon. secretary. Drs. Legrain and Boissier, of Paris, were elected honorary members of the Association. Votes of thanks were accorded to the president and officers. Previous to the meeting a demonstration, with the aid of the electric lantern, which was largely attended, was given by Dr. Ridge, in the lecture theatre, of scientific reasons for total abstinence. He showed that healthy cell-life, both vegetable and animal, was impossible in the presence of minute quantities of alcohol, while by its interference with oxidation and the removal of waste products, it injured the proper performance of every function.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JUNE 20, 1900.

THE "GRAMMAR SCHOOL" CONTEST BETWEEN THE MEDICAL COUNCIL AND THE LONDON COLLEGES.

THE reply of the London Colleges to the view urged by the Medical Council that Grammar Schools are not legitimate or recognisable centres of medical teaching, was presented to the Council on the last day of its meeting, when it would have been totally impossible to enter upon the discussion of so grave a controversy, and it was, therefore, postponed until the next meeting of the Council. An imperative hindrance to its consideration, also, was the fact that according to the new fashion of the Council's business, the report was marked "confidential," by whose authority no one knows. The reply of the Colleges occupies 15 closely printed pages, but it might, with advantage, and without making its purport ambiguous, have been compressed into five lines. Not only do the Colleges flatly refuse to withdraw their recognition of Grammar Schools as centres of medical teaching, but they proclaim at the market cross, and with the vociferation of the town crier, that they utterly repudiate the authority of the Medical Council to make or enforce any requirement whatever as to where and how and for how long the medical student shall study his professional subjects. The epigrammatic phrase in which they express this opinion is as follows:—

It is clear, therefore, that the recent action of the Medical Council . . . is entirely outside its powers, and that the attempt to enforce it, if made, by refusing registration to students of those schools . . . of which it may not approve would have no justification.

The whole of the structure of regulations and requirements which the Council has erected on the same groundless assumption of authority are invalid as such, and can only be received for what they are worth as recommendations.

Without entering fully into a discussion of the law of the question, we can at once say that, if there were no quibble in the argument of the Colleges, and if their view of the law were correct, they would have succeeded in reducing to an absurdity the functions of the Medical Council with reference to medical education. The quibble in the Colleges' case is, as is known to all, that the final decision of such a dispute as this lies with the Privy Council, to which tribunal of appeal they might bring the Medical Council if they thought fit, and where, we are confident, that no one would lend a favouring ear to the outrageous proposition that every qualifying body should adopt any course as to recognition of studies which seems likely to pay it, irrespective altogether of the sufficiency of those studies, and they make use of this quibble to lead the public to the belief that the Medical Council possess no power of insistence. We desire, however, to point out that, unquestionably, the Medical Council has ample powers, under Sec. XVIII. of the Medical Act of 1858, to satisfy itself that every item of the course of medical study is sufficient in all respects, and it can, if not satisfied, refuse to register the diploma of the applicant and leave the licensing body which issued the diploma to arraign it before the Privy Council. We must explain how this comes about, for there seems to exist the utmost obscurity in the professional mind as to what is meant by student registration, the record of his having passed in preliminary general education being almost universally confounded with the ultimate registration of his diploma in the *Medical Register*. For the preliminary registration there is no warrant in any Act of Parliament, for it was never contemplated to make it compulsory when the Act passed. It is acquiesced in by the qualifying bodies because of the universal feeling that a guarantee of the general education of the student is necessary, but if any licensing body declined to make a requirement, the Medical Council could not enforce it, nor could it refuse to register a diploma correlative with general education. On the other hand, the diplomate is legally entitled to go on the *Medical Register on production of a diploma which, in the opinion of the Medical Council, evidences the requisite standard of medical study*, but not otherwise. One of the elements in the determination of this standard is the period occupied in *bona fide* medical study, and it is as much competent for the Council to fix that period as to ordain that the student shall attend a hospital. It has fixed the essential period at five years, not five years at the will of the London Colleges, but five years at its own will and we think that there can be no doubt that it can refuse to register the testimonium of the first diplomate who comes up unless he shall have fulfilled *bona fide* five years. Therefore to be registrable, the diplomate must prove that he commenced medical study not less than five years previously, and to enable him to do this the Medical Council has instituted initial medical registration. It has no power to compel the student to effect that registration at that

or any particular date, and a student might conceivably do so in his fourth year, but in that case he could not be finally registered until he had put on five years to the fourth year. The present position stands thus: The Medical Council demands five (*bona fide*) years, the Colleges offer four years and a sham; the Council refuses that offer, and insists on genuine study of all medico-scientific subjects for full five years in a genuine medical teaching institution, and it can disfranchise every diploma brought to it for registration under any other circumstances. The only thing remaining to be done is for the Colleges to bring the Medical Council before the Privy Council on appeal, if they have the courage of their convictions, as expressed in their replication. In this condition we may safely leave the question.

THE MODERN ASYLUM.

THE new Lunacy Board of Aberdeen has recently been inquiring regarding the latest methods of asylum construction and arrangements, and, represented by a deputation, have visited a number of asylums in England and Scotland in view of the proposal to build a new asylum at Kingseat, Newmachar. The leading conclusion arrived at respecting this matter is, that there can be no question of the advantages to be derived from the adoption of the segregated type of asylum for the treatment of the insane. The site which has been purchased at Kingseat appears to lend itself readily to the development of this arrangement, for already there are three farm steadings in excellent order on the estate, and these can be increased, and in some modified form brought up to date, so as to fit in with the principle adopted at Alt Scherbitz. It appears to the Board that these separate buildings with their home-like surroundings and freedom from restraint, with the substitution of gardens for airing courts, bedrooms for dormitories, sitting rooms for halls, and open walks for corridors, cannot fail to have a beneficial effect upon those requiring asylum treatment. In coming to this conclusion it is evident that the Board has been guided and inspired by Sir John Sibbald and by the Scotch Commissioners in Lunacy, who consider that the assimilation of the life and condition of lunatic patients to everyday life is most conducive to health and happiness. The Board does not recommend that the Alt Scherbitz plan be followed in its entirety, but that its style and system should, with modifications and alterations rendered necessary by the conditions of climate, be followed by the Aberdeen District Board. It appears that the London County Council, notwithstanding the enormous expense which has been entailed in the building and furnishing of their asylums, proposes to break up at least one of their large institutions into the village type, or at least this matter is under their serious consideration. It is evident that the segregated style of asylum is being looked upon with great favour. Not only in Great Britain, but on the Continent and in America, the lock and key, block and corridor system is being superseded in several instances by the open door and

village system of treatment of the insane, and at Edinburgh the District Lunacy Board has resolved to build an asylum for pauper patients on that principle. It appears to us that quite a sufficient number of Lunacy Boards have caught on to this idea; and, while in theory it is a beautiful and humane conception, we would hope that a halt may be called before it goes too far, in order to allow time to test its practical efficiency and its economical result. If it can be proved to be more economical than the older asylums we will most cordially recognise its advantages, and will be pleased if it can demonstrate from a strictly medical point of view that it obtains better results. We must confess, that while the Edinburgh asylum, which takes the lead in this departure—we hope that it will be as economical as its supporters expect—has been the occasion of considerable expense to acquire Parliamentary powers for railway and water supply, and we are exceedingly doubtful that it may be the most expensive asylum in Scotland for construction and management. The Aberdeen Board have also had their attention drawn to the manner in which Continental and English asylums provide analytical and pathological laboratories, and the question of the disposal of asylum sewage has received their consideration as well; but these things must be judged by results. It is all very good to make outward show, but the hard-headed rate-payers will always come up on top with the question, What have we got for our money?

THE PATHOLOGICAL BEARINGS OF PYORRHOEA ALVEOLARIS.

THE affection known to dentists as pyorrhœa alveolaris is not one in respect of which the average practitioner professes to know very much. Even teeth specialists, though they fully recognise its existence and frequency, do not appear to be fully alive to its pathological bearings, and their attempts at treatment are not characterised by any great measure of success. This disease was the subject, at last week's meeting of the Royal Medical and Chirurgical Society, of a paper by Mr. Godlee, who drew attention to the various complications, both surgical and medical, to which it may give rise. Formerly known as Rigg's disease or "spongy gums," the condition is characterised, as the popular name indicates, by a peculiar sponginess of the gums, which bleed readily on slight pressure, and by a suppurative inflammatory process affecting the periodontal membrane, associated with the formation of pockets between that membrane and the teeth, which are the seat of very active microbial proliferation. Its medical interest lies in the obvious risks which this septic focus at the very entrance of the *primæ viæ* must entail. It is not regarded as due to any specific micro-organism; indeed, some twenty-five varieties of bacteria have been identified in the pus-secreting cavities; but pyogenic organisms are always present in considerable abundance, and the

constant passage of these and their products into the body necessarily exposes the sufferer to the danger of septic absorption and even under certain circumstances to pyæmic infection. The discussion which followed the reading of the paper quite unexpectedly brought to light a large series of morbid phenomena to which this condition appears to stand in casual relationship, theoretically at any rate, since, so far, no direct bacteriological evidence of these suggested relationships is forthcoming. It is not surprising to hear it suggested that the debilitating influence of this process of slow poisoning is responsible for many of the functional nerve affections from which women suffer, and the list of these is a long one. Even more plausible is the suggestion that some cases of malignant endocarditis which, in the absence of any obvious portal of entry for the infection, are termed idiopathic, may owe their existence to this centre of infection in the mouth. There is much to be said in favour of this view which may help us to explain what are, so far, a very mysterious group of cases. The presence of pyogenic organisms in the mouth, moreover, may explain the readiness with which secondary infection complicates tuberculous and other diseases of the lungs, and, as the author mentioned, may account for the factor in cases of bronchiectasis. It is even suggested that certain cases of pyonephritis may have derived their infective elements from the same source, and Mr. Spencer related a case in which the two conditions co-existed, and although, even in the absence of any other obvious cause, this may not carry conviction, the co-existence of two such well-marked diseased conditions cannot but suggest a possible interdependence. Again, pyorrhœa alveolaris when well marked is sometimes associated with enlargement of the lymphatic glands in the neck of the kind which would generally be described as tuberculous, so that in such cases the physician ought always to examine the mouth in order to determine whether it be the source of the glandular tumefaction. It is to be remarked that this disease rarely presents itself in persons presenting the typical aspect of health, but a depreciated standard of vitality may be either the cause or the result of the dental affection. That pyorrhœa alveolaris is a local and not a constitutional affection is rendered probable by the fact that it usually commences in two or three teeth, and then spreads to the rest, and also by its amenability to local germicide and antiseptic measures, constitutional medication exerting no effect in the direction of a cure. The term cure, indeed, is hardly applicable to this affection, which displays an irrepressible tendency to recur so soon as the routine treatment is suspended, though, curiously enough, extraction of the teeth puts an end thereto. It is also remarkable that, in spite of the existence of these bacteria-infected sockets, infection of the extraction wounds is a rare complication. It is hardly necessary to insist on the importance of eliminating this possible source of infection before attempting operations on the tongue or jaws, for surgeons, we

presume, are fully alive to the danger. The question is one of peculiar interest, and it is obvious that pyorrhœa alveolaris can no longer be relegated to the domain of dentistry, in view of its far-reaching effects on the organism as a whole.

Notes on Current Topics.

Enteric Fever in Paris.

THERE are but few Britons of the present day travelling on the Continent who are unaware of the dangers arising from drinking the water of the country, or from partaking of unboiled milk, or eating raw fruits without first removing the skin, but there are certainly an appreciable number who are foolish enough not to profit by this knowledge. It is to be hoped that the somewhat alarming news that is now being circulated of the great increase in the number of cases of typhoid in Paris may prove to be exaggerated, but it will, at any rate, serve as a useful reminder to those who purpose visiting Paris that the possibility of contracting such an insidious disease as typhoid is not wholly imaginary, and that it is very advisable to follow out the well-known and simple prophylactic measures enumerated at the beginning of this paragraph. Suspicion has fallen on the water supply of Paris, especially that from the Vanne, and if, as is alleged, the incidence of the cases of the disease is found to coincide with the area of the distribution of the suspected water supply, the importance of the matter cannot any longer be belittled. Much doubt is thrown on the official statements and explanations of this untoward occurrence, and although the attitude of unreasoning hostility towards any evidence of a reassuring nature simply because it is official, may appear to be wanting in ordinary charity, the official attitude in past epidemics, it must be admitted, has not always been such as to inspire confidence.

The Feeding of Children and School Authorities.

SIR J. GORST prophesied a few nights ago that posterity will view with surprise and wonder our present-day management of the question of feeding school children, and will marvel how this generation was so stupid as to tolerate it. For insisting last year on the somewhat elementary fact that children should be fed before they were taught, Sir J. Gorst brought down on himself a storm of reproach, and possibly this not ineffectual method of opposition may shortly be again resorted to in order to thwart his objects this year. It would be difficult to surmise what sound arguments can be urged against the opinions of the representative in Parliament for Cambridge University on this subject. Children are compelled to attend school by the authorities, and this necessarily entails, or should entail, adequate provision that the children shall be in a fit state to receive instruction. By a proper administration of the law this public duty should be strictly

enforced on the parents, and if this were efficiently done there would not be many cases of children attending school unfed and incapable of deriving any benefit from the teaching provided. The real offenders are not the poor parents, but the wilfully negligent parents who in some cases starve their children to satisfy an infamous greed for their pitifully small earnings. We sincerely trust that Sir J. Gorst will be enabled to devise some ready means of reaching these offenders, and of making them feel in some effectual manner the necessity of fulfilling one of the most fundamental of all obligations to their unfortunate offspring.

An Accusation against a Hospital Board of Management.

It is given to few institutions to have the assistance of such a brilliant and able honorary medical staff as that attached to the National Hospital for the Paralyzed and Epileptic, and any document which is signed by the medical staff of that great charity naturally commands the closest attention. We have received from one of the subscribers to this institution a copy of a printed statement signed by all the members of the medical staff, embodying grave charges against the Board of Management. The signatories characterise the administration of the hospital as "very unsatisfactory," and express the conviction that the reputation and future success of the institution is in serious jeopardy. The gravity of the matter cannot be overlooked, for the signatures of Sir Wm Gowers, Dr. Hughlings Jackson, Dr. Buzzard, Dr. Ferrier, Dr. Bastian, Sir Felix Semon, and the other distinguished medical men giving their services to the patients at the hospital in Queen Square, naturally carry so much weight and significance that it is difficult to appreciate the attitude of the Board of Management in refusing to accede to the very moderate demands made by the eminent body of scientific men who constitute the medical staff of their hospital. The present condition of things appears to be primarily due to the fact that the medical staff is not directly represented on the governing body of the hospital, and it is pointed out with every appearance of justice that general experience has shown that such representation is necessary in the best interests of the suffering poor. As a matter of fact in all the Metropolitan hospitals having 100 beds or more, save two, the medical staff is directly represented on the board or committee of management.

Urban Ambulances.

It is somewhat astonishing, considering the elaborate arrangements made for the care of the sick and wounded in our large towns, that so little attention has been given to ambulance provision. In London, for example, hardly a large general hospital possesses an ambulance carriage of its own, and patients have to be brought to the hospital, no matter how desperate their plight, in a sorry four-wheeler, or, in case of accident on the highway, on the two-wheeled police stretcher. The Metropolitan Asylums Board is provided with a fairly adequate ambulance ser-

vice, but it is costly, and is only available for the transport of persons suffering from infectious diseases. Surely this is a matter which ought to receive early attention at the hands of Councils, and especially of the London County Council! In all large continental towns, as well as in the principal cities of the United States, a special feature is made of this service, and it is odd, to say the least, that London should be lacking in this respect. Failing an administrative service, the provision of carriages suitable for the transport of the sick might well be undertaken by private enterprise. If it were publicly known that such carriages could be had at a moderate cost and at short notice we have no doubt that the service might be made to yield a fair return on the outlay, and we commend this suggestion to the notice of those who cater for the public requirements in the matter of locomotion.

Increase of Insanity.

DR. W. W. IRELAND has been dipping into the vexed question of the increase of lunacy. He has addressed a series of questions to a number of the leading medical men in the country, in order to ascertain whether they have observed an increase in the relative frequency of diseases of the nervous system. Several doctors give their opinion that nervous affections are on the increase, and their testimony is quoted as having an important bearing on the lunacy problem. Undoubtedly, there is a great deal of common sense in this view, and there can be very little question that nervous diseases come more under notice than formerly. Professor Erb, a well-known neurologist and distinguished authority on the subject, gives as among the factors producing nervous diseases, irritation and depression, the greater anxiety, hurry, mental toil of life, overwork at school, and so forth. However, there are other causes to be found in the excesses of our times, and the pace at which we live. It is probable that lunacy is really more on the increase than our official authorities will admit, and the question is, can we do anything to arrest the increase without attempting to revolutionise our present so-called civilisation?

An Epidemic of Suicide.

CAPITAL is being made by some of the evening dailies out of an alleged epidemic of suicides in the Metropolis. There really seems to be some ground for the rumour in that the number of deaths from suicide, or reputed such, is greatly in excess of the average. On scrutinising the returns of suicide we find that there is not nearly as much mystery as one might expect. The number, year by year, is singularly uniform, and the prevalence of a desire to put an end to life corresponds to certain well-recognised factors. Curiously enough the months during which the proportion runs highest are not those of gloomy autumn or rigorous winter. It is in sunny June or burning July and August that people weary of life and seek their quietus. Then, too, every wave of popular excitement tends to send up the numbers as

if the prevailing excitement intensified and exasperated a pre-existing frame of mind and raised despair to the lethal pitch. As insanity increases we must expect a steady rise in the number of suicides, indeed suicide might well be described as the natural termination of certain forms of mental aberration.

Working Men Representatives on Hospital Boards.

THE question of the representation of working men on the boards of management of our medical charities is one of great social importance. Hitherto the government of these institutions has been handed over to philanthropists in whom, to say the least of it, the quality of mercy is not invariably tempered with calm and reasonable justice. Two classes suffer mainly from the unthinking administration of hospital relief, and in both instances the origin of the evil lies in the gratuitous or paid treatment of persons other than the poor for whom the hospitals were founded. The working classes suffer because they are crowded out of the wards by patients who should be at home paying their own doctors; by the shoals of trivial cases that are treated daily in the out-patient departments; and by the diversion of beds and income to the behoof of part-paying patients. Medical men form the second-class injured by hospital mismanagement. Their aggregate loss by unfair competition in the above-named directions is enormous, and for that they have to thank the philanthropists who have so long turned a deaf ear to expostulation. The working men are treating the matter in a practical way, and are either withdrawing their subscriptions, as in the case of the London Hospital, or insisting on adequate representation, as they are doing at the Cardiff Infirmary. When will medical men adopt the common-sense of securing a proper place in the management of the medical charities by seeing that a fair proportion of the members of managing committees comes from their own ranks? The flood of hospital competition will never be turned until the public are properly instructed as to the facts of the case.

The London Lunacy Scandal.

CIRCUMSTANCES that are coming justify our surmise as to the implication of the relieving officers of other parishes than that of St. Pancras. It seems that a Local Government Board inquiry was actually made some months ago in the case of Bethnal Green. If that be so the sooner the results of that investigation are made known the better will the public be satisfied. Any attempt to hush up matters in connection with this scandalous system of lunacy blackmailing can end only in disaster now that the attention of the community has been drawn to the matter. So far as Bethnal Green is concerned, it seems that both Dr. Kempthorne and Dr. Berdoe acknowledge that they have never been in the habit of paying five shillings to the relieving officers for each pauper lunatic brought for certification. Dr. Berdoe, presumably the anti-vivisection advocate, appears to have thought it consistent with the claims of humanity

as regards the human species to pay these sums until recently. The Bethnal Green relieving officers appear to have admitted with refreshing candour that they had received payments from the asylums. One of them said two guineas was paid for each patient by Hoxton House and Bethnal Green House asylums. Any patient ordered to Claybury, where nothing was paid, was taken to one of the first mentioned. Another witness had received presents from Grove Hall Asylum, and from Fisherton House Asylum at Salisbury.

Arsenic in a Popular Purgative.

A RUMOUR of a most alarming nature has within the last few days been made public with every appearance of truth. It is said that a great firm of chemists have for the past six months been issuing a granular phosphate of soda which has recently been found to contain a dangerous proportion of arsenic. The firm in question have issued a circular to chemists stating "that the phosphate of soda lately supplied by them contains a dangerous percentage of an arsenical preparation." They further admit that this defect applies "to all phosphate of soda supplied from November 15th, 1899, until the end of April, 1900." The prospect thus opened up of wholesale and unsuspected poisoning is simply appalling. Phosphate of soda, as most persons know, is a mild aperient extensively used among babies and children. The effect of arsenic would be to produce cramps, vomiting, purging, watery and choleraic stools, in short, symptoms like those of summer diarrhoea. It is almost certain that any death so caused, in the absence of any symptoms pointing to arsenical poisoning, would be referred by the medical attendant to the disease mentioned. It is therefore not improbable that during the last six months many deaths of children have been improperly ascribed to diarrhoea whereas their true nature was acute arsenical poisoning. The publication of this news should put medical men on the look-out in all parts of the United Kingdom, for, strange as it may seem, it is sometimes extremely difficult to diagnose a poisoning case off-hand, especially in children.

Homes for Idiots and Imbeciles.

THE leading men in the county of Derby have been moving towards the question, what can be done towards establishing a special home for idiots and imbeciles? The general result of their deliberations is, that there is need for a special institution, because many of those afflicted beings are really a danger to the community at large, and yet are not insane enough for asylum treatment. It can be done if we had a properly organised system of administration and education. At present, however, there is a difficulty because of the indifference or inability of our County Boards of Lunacy, and at present in the county of Derby all that has been done is to make a motion on behalf of the movement so as to stimulate the county to take steps in the matter.

The Results of Anti-Typhoid Inoculations in the Army.

THE public have awaited with anxious curiosity the result of the anti-typhoid inoculations from which so much was hoped when permission was given to the experimental and voluntary application of the method to soldiers going to the front. The terrible ravages of enteric fever among the troops in the field will have prepared the public in great measure for a disappointment, and we regret to find that the statistics, as far as they go, tend to substantiate what has hitherto been but a surmise. According to Surgeon-General Jameson, the figures are the reverse of encouraging; and although at the present juncture it may not be possible to place the results before the public in numerical formulæ, it is but too evident that the hope of having at last discovered a means of affording immunity against this fell disease must be abandoned. But the results, as far as they go, justify something more than mere disappointment, for the inoculated officers seem to have suffered in a somewhat larger proportion than the non-inoculated, and to have exhibited a higher case mortality, differing in this respect from the results of inoculation of the men, such of the latter as availed themselves of the operation contracting typhoid in less proportion than their fellows. When, however, they did contract the disease the same high case mortality was observed as among the officers. It is too early as yet to draw any far-reaching conclusions from this experiment on a large scale. That this method of inoculation does afford a measure of protection under certain circumstances experience seems to show conclusively, but it may be that the protection is relative and not absolute, in other words, that its value diminishes as the dose of infection increases, and disappears altogether when the dose exceeds a certain limit. This is more or less true of all processes of immunisation and cannot cause surprise, and it leaves us with the hope that further study will enable us to enhance the protective power of the serum, and ultimately to withstand an indefinitely large dose of the *materies morbi*.

Entertainments to Members of the International Congress of Medicine, Paris.

WE are asked by the executive committee to give notice that the following entertainments will be provided for members of the Congress:—On August 2nd, the day on which the Congress is opened, M. Lannelongue, the President of the Congress, will hold an evening reception in the name of the Government of the Republic. On August 3rd, members will be invited to an evening *conversazione* by Professor Lannelongue, in his capacity as President of the Congress. On August 5th the members of the Congress will be received in the evening by the President of the Republic at the Elysée Palace. On August 8th an evening fete will be held in the Palais du Sénat and the Luxembourg Gardens, when the members will be received by the Executive Committee. The Municipal Council of Paris will be asked to entertain the members, and other fetes will

be organised by most of the sections. The wives, daughters, and sisters of members of the Congress will be invited to all the entertainments, and a Ladies' Committee has been formed to promote their interests.

The Council Election of the Royal College of Surgeons of England.

THE list of candidates closed on the 11th inst., and there are now thirteen candidates in the field to compete for the honour of filling the four vacancies on the Council of the Royal College of Surgeons, a number which, we believe, is unprecedented. It is highly probable that some of the candidates will find it desirable to withdraw as soon as they find they cannot rely upon any great measure of support, especially as two of the retiring members are seeking re-election with every prospect of success. We wish we could draw some reassuring inference for the profession from the keenness with which the honour of the councillorship is sought after, but we fear that personal advancement—the desire to share in the good things of which the College disposes, is at the root of the ambition and not any set aspiration to make the Fellows and Members of the College one large and happy family. As matters stand the upshot of the election presents little interest to the great body of members, and probably does not arouse much excitement even among the Fellows, outside the favoured few who hope to win their spurs.

The Jenner Institute.

THE Jenner Institute, established at Chelsea, S.W., has been unsuccessful in the endeavour to escape being rated, the judges in the Queen's Bench Division holding that "the object of the institution was mainly for the preparation and sale of medicines." Mr. Justice Channel drew a distinction between institutions which exist for the promotion of science and those which have for object to dispense to the public the benefits of science. Doubtless, the Jenner Institute answers both descriptions, but inasmuch as its object is primarily the advance of science, it seems somewhat unjust that the preparation and sale of pure sera, carried on, as it must be, at a loss, should deprive them of the exemption always accorded to scientific institutions in respect of the payment of rates. After all, the amount at stake is of no great importance if we consider the value of the services rendered to the profession, and through it to the public, in the department of serumtherapy.

The Character and Value of New Drugs.

THE Medical Society of the State of New York has passed a resolution in which it urges that the interests of medical science require that the pretensions of new medicines shall be subjected to "disinterested investigation." To that end it suggests that the decennial convention shall establish a bureau which shall examine not only into the truthfulness of the representations made with reference to the constituents of new drugs, but also as to their action as therapeutic agents.

A Demand in Rehabilitation.

MR. JUSTICE GRANTHAM was called upon to adjudicate on a somewhat unusual application in the Queen's Bench Division last week. Mr. Bynoe, a qualified practitioner of medicine, whose name was removed from the *Medical Register* some nine years ago, following on his conviction for perjury, applied for a *mandamus* to compel the General Medical Council to reinstate his name, on the ground that facts exonerating him from participation in the crime had since come to light. The application was adjourned because, forsooth, the affidavit was written on only one side of the paper.

THE Hospital for Epilepsy and Paralysis, has received from the executors of Mr. J. W. N. Bentley a munificent gift of £5,000, and from the trustees of Smith's (Kensington) Charity a grant of £50.

THE death is announced of Dr. Cadet de Gassicourt, of Paris, a well known authority on infantile pathology.

PERSONAL.

DR. WM. MAERMADEK BERGIN has had conferred upon him the Associateship of University College, Bristol.

PROF. ROENTGEN has been selected by the Columbia (U.S.A.) University as the recipient of the Barnard gold medal.

MISS COWAN has been appointed assistant medical officer to the West Ham Workhouse, out of twelve candidates.

PROFESSOR ALFRED HUGHES is leaving to go to the front, to replace Prof. Thomas Jones, who has been invalided home.

LORD LISTER has consented to deliver the third annual "Huxley Lecture" at Charing Cross Hospital on October 2nd.

DR. G. H. F. NUTTALL has been appointed University Lecturer in bacteriology and preventive medicine at Cambridge.

MR. FREDK. TREVES will distribute the prizes and certificates to successful students of the London Hospital on July 19th.

DR. J. FARRELL EASMON, of Cape Coast, West Africa, is reported to have succumbed to an attack of pneumonia on the 9th inst.

AMONG the list of wounded in last Saturday's railway accident at Slough we regret to see the name of Dr. James Clarke, 4, Carlton Chambers, Piccadilly.

DR. SYDNEY STEPHENSON has been appointed Honorary Secretary of the provisional committee for the formation of a society for the study of children's diseases.

DR. THOMAS BARLOW is to deliver an address on "Raynaud's Disease and its Allies," to-morrow (Thursday) to the Bradford Medico-Chirurgical Society.

DR. O. J. KAUFFMANN will deliver the Ingleby Lectures at Mason's College, Birmingham, on June 27th and July 4th on "The Commoner Neuroses of Children."

DR. MARY PIERSON EDDY was, until recently, the only

woman allowed to practise in Turkey, and is said to have founded the only ophthalmic hospital in Syria. She is at present in the United States.

MR. A. B. GREEN, M.A., M.B., B.C., of Downing College, Cambridge, has been awarded the Raymond Horton-Smith Prize for the best M.D. thesis of the year. His subject was "Amyloid Disease."

ON the occasion of the distribution of prizes at Guy's Hospital on July 4th, by the Right Hon. the Earl of Pembroke and Montgomery, the guests are invited to join with the Governors and medical staff in assuming academic costume.

DR. JOHN HALLEY, M.B., C.M., has been nominated by the University of Aberdeen and accepted by the War Office for medical service among the troops in West Africa. He has had experience of hospital work in the West Indies, and embarks for Sierra Leone on Saturday next.

MR. WILLIAM TURNER, of Queen Anne Street, London, one of the surgeons on the staff of the Imperial Yeomanry Base Hospital at Deelfontein has sustained a fractured jaw and other injuries as the result of a fall from his horse, but it is hoped that he will be enabled to resume his duties in about a week.

MR. L. M. GRIFFITHS, who recently retired from the post of assistant editor of the *Bristol Medico-Chirurgical Journal*, has been presented with a book-case containing the "International Library of Famous Literature," a silver bowl, and an illuminated address, as tokens of the appreciation by the members of the society of his labours on their behalf.

SINCERE expressions of sympathy will be evoked for Mr. Bryant, ex-president of the Royal College of Surgeons, England, on the death, at Bloemfontein from enteric fever, of his son, Dr. Hugh A. Bryant, who volunteered to serve in the Royal Army Medical Corps in South Africa, and whose services were highly appreciated in that capacity.

WE understand that at the Degree Day at Victoria University, Manchester, on the 30th inst, the M.D. Honoris Causa will be bestowed on Hubert Armstrong (University), Alfred Greenwood (Owens), J. A. MacLaren (Owens), W. A. Newall (Owens), and F. W. Stansfield (Owens), and Doctorate in Science on H. T. Ashton (Owens), W. H. Bentley (Owens), F. W. Gamble (Owens), and George Wilson (Owens).

THE year 1900 has been marked by the addition of two medical students to first-class county cricket. In Middlesex there is Mr. E. S. Littelljohn, an old St. Paul's Schoolboy, who distinguished his first appearance by making top score—29—for his team against Notts. He is the son of Dr. Littelljohn, the well-known Medical Officer of the London and District Schools at Hanwell. So far, none of the newspapers have grasped the correct spelling of his name, and we are pleased to throw out this information for the behoof of all sporting editors. The second medical student cricketer is Mr. H. T. Hodgkins, who has made some very useful scores for Gloucestershire. He is entered at the Bristol School of Medicine, where the three Graces formerly attended. We cordially hope he will keep up the tradition of the Bristol Medical School in that particular field of sport.

Manchester.

[FROM OUR OWN CORRESPONDENT.]

OWENS COLLEGE.—Rapid progress is being made in the erection of the Whitworth Hall, which will form one of the largest and most elegant of the college buildings. The new building to be devoted to physical laboratories is now completed and is to be opened on June 29th. Ashburne House, the new Hall of Residence for Women, is proving a great success. Arrangements are being completed for the admission of women as medical students next session at the college and the infirmary. The Anatomical Society of Great Britain and Ireland is holding its annual meeting at the Owens College this year.

SMALL-POX.—Manchester, Salford, and district have been threatened with an outbreak of variola, originally introduced from Russia, but the prompt action of the health authorities seems to have effectually prevented a spread of infection, and only a limited number of cases have come under treatment.

WELSH HOSPITAL.—Much sympathy is felt for the misfortunes which have followed the staff of the Welsh Hospital in South Africa. Professor Thomas Jones, who is Professor of Surgery in the Owens College, and one of the principal surgeons and joint treasurer of the Welsh Hospital, is an invalid, and is to be succeeded by Professor Alfred Hughes.

WATER SUPPLY.—A second pipe is about to be laid from Thirlmere lake to the city at an estimated cost of half-a-million sterling. The present supply of water will thereby be doubled. The work of construction will take three years. Meanwhile Manchester has to study economy during summer months in its use of water, which certainly seems an unreasonable virtue for "the watering-pot of England."

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

INJECTION OF SUBJECTS THROUGH THE VASCULAR SYSTEM.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In a notice of the late Professor G. Viner Ellis's useful work, in the teaching of anatomy at University College, London, by Mr. Balmanno Squire (*British Medical Journal* June 2nd, 1900), it is stated that "about the year 1855" . . . "because in those days it never occurred to anyone to arrest the putrefaction of the subjects by the injection of preservative fluid into the arteries in the manner that is done nowadays." Allow me to say that I was taught anatomy by the late eminent Professor Alcock, of Dublin, who in the forties (1840-1843 and subsequently) used what Mr. Squire names "preservative fluid injections into the arteries." This enabled me and others to dissect in the early summer mornings, as well as in the winter time.

Thanking you in anticipation for your insertion of this measure of "justice to Ireland."

I am, Sir, yours truly,

C. F. MOORE, M.D., F.R.C.S.I.

10, Upper Merrion Street, Dublin, June 10th.

[Our correspondent is quite right. Antiseptic solutions then called "preservative" solutions, were injected through the arterial system by lecturers on anatomy in the Dublin Schools as far back as the thirties. Alcock used them in the Peter Street School where he succeeded Brennan. When he left the Peter Street School, with Mr. Andrew Ellis, to join the newly-established School of the Apothecaries' Hall he continued the practice. Professor Kirby of the Peter School also used a "preservative" fluid, and conducted dissections during the summer months. During John Hatch Power's

term as Professor of Anatomy in the R. C. S. Schools he invariably injected a "preservative" fluid. The preparation of the fluid and its injection came to be done by the anatomy-room porter, and it is said that in the R.C.S. School the secret was lost some years ago, on the death of Sherman. The fluid was said to be an alkaline solution of arsenic; others say that in some of the schools a solution of corrosive sublimate was used. A distinguished anatomist of the Dublin School, who had lived in the days of the "sack-em-ups," told us that the fluid was a saturated alkaline solution of arsenic. At first the fluid was injected through the left auricle of the heart, but latterly it was injected through the thoracic aorta.—ED.]

MIDWIVES' REGISTRATION.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The protest published this week in the medical press from the Beckenham and Penge Medical Society regarding the conduct of the Cannon Street Hotel meeting, contained in a letter of sympathy to Dr. Glover, would not require an answer did it not contain the statement that the delegates of that society went there "prepared to submit some very carefully considered alterations in the Midwives' Bill, which they hoped might render it a useful measure, and one which would safeguard the public and be acceptable to the general practitioner."

Of these "carefully considered alterations" we heard nothing either at the preliminary committee meetings or at the meeting itself. And how can this statement be made consistent with this society's delegates (including Dr. Sturges) having composed and signed the following, which is an extract from a letter which accompanied the invitation to the meeting? "It is the opinion of the large majority of medical men, and particularly of general practitioners, who see most, and know most, of the class of work the Midwives' Bill is intended to legislate for, that it is a measure likely to effect incalculable harm. Even if it provided, as it does not, for restricting to natural cases of labour only the legal attendance of midwives, the harm would not be guarded against, for a natural case of labour requires complete scientific knowledge to diagnose, and may become urgent and dangerous at any time between its commencement and completion. Since the study of midwifery has been changed, chiefly owing to the labours of the late Sir James Simpson and the Edinburgh School, from a despised art to an honoured science, the saving of life and suffering has been immense (as statistics will show) and the genus Mrs. Gamp, so powerfully exposed by Charles Dickens, has been disappearing by the ordinary process of evolution. That being so, the evil which we all recognise to exist, seemed to be gradually curing itself; but the effects of this legislation we fear will be to revive it in a more dangerous form than ever existed before."

"The Medical Acts, which were drafted in the interests of the public, wisely ordained that medical men, who are licensed to practise in any one branch of medicine or surgery (including midwifery), must show a thorough knowledge in all. Going absolutely against this principle, the Midwives Bill will give a State-guaranteed qualification to women, who can, at most, possess the little knowledge that is dangerous, which will deceive the public into thinking that in employing a midwife they are employing a properly qualified person to whom they are justified in entrusting their lives. We feel very strongly that this Bill has not been properly considered, or the effect it will have sufficiently weighed; and although we wish all who follow the calling of nurse to the sick could be properly trained, and even certificated by law, we are convinced that no measure which provides for the attendance of lying-in women without proper medical supervision can fail to be productive of a largely-increased death-rate among women and infants, and also do much to encourage criminal practices."

This is the rational and consistent position which we still hold, and the one from which they have apparently been washed back by the dogmatic ground-swell of medico-political orthodoxy.

Yours very truly,
F. LORIMER HART.

Sydenham, June 17th, 1900.

THE FELLOWSHIP OF THE ROYAL COLLEGE OF PHYSICIANS OF LONDON.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—It must be admitted that your correspondent, "An Indignant Member," has managed to ferret out one or two instances in which worthy members of the Royal College of Physicians have not received the Fellowship. At the same time I maintain the truth of my general assertion that the Fellowship is neither unduly withheld nor improperly bestowed. I think your correspondent would have to cudgel his brains sorely to find any other names to add to his list. Of course I do not mean to say there are not a number of members attached to provincial hospitals who may be said to deserve the honour so far as the lapse of years is concerned. Most of these gentlemen, however, although of sound social and professional standing, are mere general practitioners, and are no more fitted for the distinction of the Fellowship than the ordinary "G. P." who is at the beck and call of everybody.

Take analogous distinctions, such as, let us say, the K.C.B. What would be the result if that honour were bestowed upon any but a strictly delimited and defined class of men? Undoubtedly, to my mind, the system of social distinction is one of the mainstays of society. Why seek to decry the lofty ethical position assumed by the London College of Physicians?

I am, Sir, yours truly,
AN INDIGNANT FELLOW.

Brook Street, W., June 17th, 1900.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In my opinion you deserve the thanks of the profession for opening your columns to the discussion on the question of the election of Fellows at the Royal College of Physicians, London. The letter of your correspondent, an "Indignant Fellow," was only an attempt to throw dust in the eyes of those who do not know the facts of the case in regard to these elections. I challenge any Fellow of the College to deny that he has not owed his election mainly to the personal solicitation of friends. The high falutin' nonsense about "Honoris Causa" does not call for refutation; nor is it likely to mislead any one who has paid attention to the subject. The Fellows of the College form as close a borough as exists anywhere in the Kingdom, and, whatever may be said to the contrary, this inner collegiate circle have in their time perpetrated many acts of injustice. It is dreadful, I admit, to attack these would-be upholders of everything which is high and noble in medical etiquette, and one can easily understand how shocked they must all feel by being thus brought under the public gaze. But facts are stubborn things, and the college authorities cannot ignore them in this instance.

I am, Sir, yours truly,
DIPLOMATE.

London, June 13th, 1900.

Obituary.

DR. JULIUS ALTHAUS.

We regret to announce the death of the well-known neurologist, Dr. Julius Althaus, on the 11th inst., at the age of 67. He was born at Detmold, in Germany, and was educated at Bonn, Göttingen, Heidelberg, and Berlin. After taking the degree of Doctor of Medicine at the last-mentioned place he went to Paris, Vienna, Prague, and London. He eventually decided to settle in London, where he became Assistant to the Electrical Department of King's College Hospital. In 1860 he

became Member of the Royal College of Physicians of London. In 1868 he founded the Regent's Park Hospital for Epilepsy and Paralysis, the first place in the world where a brain tumour was diagnosed and localised prior to removal by operation. Dr. Althaus was the author of a number of medical works, and was a recognised authority on the medical uses of electricity. He had a large practice, and was the centre of a wide circle of devoted friends. The immediate cause of death was gouty phlebitis and peritonitis.

LIEUTENANT-COLONEL ARCHIBALD ADAMS, M.D., F.R.C.S.I.

LIEUTENANT-COLONEL ARCHIBALD ADAMS, M.D., F.R.C.S.I., administrative medical officer in Rajputana, whose death, on May 20th, at Mount Abu, India, deprives the Indian Medical Service of one of its most distinguished members, was born in March, 1850, and studied medicine at the Royal University of Ireland, where he graduated as M.D. and M.Ch. in 1872, taking the Fellowship of the Royal College of Surgeons, Ireland, in 1886. In the early part of his career he served in the Naval Medical Service, first as additional Surgeon in her Majesty's ship 'Battlesnake,' and subsequently as assistant surgeon in the 'Excellent.' He was engaged in the Ashanti war of 1873-74, for which he obtained the medal. In 1875 he resigned his appointment in the Navy and entered the Indian Medical Service, and for a few years was surgeon in the Madras Army. He became surgeon-major in 1887, and lieutenant-colonel in 1895. In 1881 he was appointed Government medical officer of the Jodhpur Political Agency and Residency. This appointment he continued to hold, except for two brief periods, until his death. Lieutenant-Colonel Adams was the author "The Western Rajputana States, a medico-topographical and general account of Marwar Sirohi and Jasailmur," a work which was only published last year.

Laboratory Notes.

PLASMON.

PLASMON is the name given to a soluble albumen prepared from milk. It is a white micaceous powder, tasteless and odourless, of neutral reaction, and readily soluble in warm water, a property which enables it to be incorporated with almost any article of food.

Analysis shows plasmon to contain about 87 per cent. of nitrogenous matter, that is to say, it represents weight for weight, five times as much proteid as fresh butcher's meat, and twenty times as much as pure fresh milk. The mineral constituents consist chiefly of phosphates which are the natural salts contained in fresh milk.

Plasmon, then, is a concentrated nitrogenous food, in a form which readily lends itself to assimilation, and can be used to reinforce the nutritive value of other foods such as milk, beef tea, soups, &c. Itself devoid of characteristic flavour its presence does not detract from the palatability of the vehicle, the value of which is thereby enhanced to the degree which may be thought desirable.

Plasmon is quite free from any diluent, such as starch, salt, or sugar, and its keeping properties are, under ordinary circumstances, perfect.

The manufacturers prepare an appetising chocolate containing plasmon as well as plasmon biscuits and plasmon bread. Plasmon chocolate constitutes an ideal "emergency ration," and will doubtless find a wide field of usefulness in that direction, the biscuits being the natural complement of the ration.

The Plasmon bread, a specimen of which has just reached us, does not appreciably differ in appearance or flavour from ordinary well-baked bread of fine quality, although, from a dietetic point of view, it represents both bread and meat. It is stated to contain 10 per cent. of plasmon, which is as large a proportion of nitrogenous matter as it is desirable to incorporate. The digestibility of the bread does not appear to be hindered by the addition, nor does it tend to turn sour.

Medical News.

Annual Dinner of the Indian Medical Service.

THE officers of the Indian Medical Service held their annual dinner at the Hotel Cecil, on Thursday last, June 14th, under the Chairmanship of Sir Trevor Lawrence. After the usual loyal toasts had been duly honoured, "The Sister Services" was proposed by Surgeon-General C. Sibthorp, who referred to the attack that had been made upon the Army Medical Service by a Scotch professor at the meeting of the British Medical Association at Portsmouth, and gave it as his opinion that the standard of education was perfectly adequate. The toast was responded to by Sir Henry Norbury, Director-General of the Naval Medical Department, who observed that the officers of the Indian Medical Service would be welcomed by the Naval medical officers if, in consequence of what was then happening in China, their duty should be to work together in that country. Surgeon-General J. Jameson (Director-General A.M.S.), also replied to the toast of "The Sister Services." He said that they had at the present moment in South Africa no fewer than 8,000 men engaged in the medical care of the troops. He spoke in high terms of the employment of civilian bearers, whom the irreverent called "the body-snatchers," but who did a very useful work, and did it well. Referring to the arrangements for men invalided from the seat of war, he mentioned that these were arriving in England at the rate of about 2,000 a week, which put the military hospitals to a severe strain. They had not up to the present moment required to make use of the civil hospitals, though they had received thousands of offers of accommodation for soldiers in convalescent homes. These came very often from very worthy good-natured old ladies and others; but, strange to say, "Tommy" would not go to these places. He preferred to go on furlough, or remain at Netley or at some military hospital, rather than go to these homes. The consequence was that these well-meaning people, after having gone to great expense in furnishing these homes and equipping them as hospitals, had been much hurt because no use was made of them. Surgeon-General Jameson then referred to the effect of inoculation for enteric fever, with regard to which it was still difficult to get accurate statistics. He mentioned that he had obtained a return of sickness in Ladysmith during the siege, and the result was certainly somewhat singular and rather difficult to explain away. The whole matter, however, was complicated by the conditions which necessarily accompanied life in a besieged town, and it was impossible to formulate any general conclusion. The Chairman next proposed the toast of "The Guests," to which Dr. W. S. Church (President of the Royal College of Physicians) made reply, and mentioned that the names of Ross and Manson were known to all in active work. Dr. Frederick Roberts (President of the Medical Society of London) gave the toast of "The Indian Medical Service," which was responded to by Surgeon-General Sir Joseph Fayrer, and the proceedings terminated with a vote of thanks to Lieutenant-Colonel P. J. Freyer, to whose experience and indefatigable activity the success of the evening was admitted to be largely due.

Cocaine Poisoning.

An inquest was held at Hampstead last week on the body of an elderly female who had succumbed to the effects of a large dose of cocaine for the relief of sleeplessness.

Death Under Chloroform.

A MAN, æt. 45, of Dukinfield, near Manchester, died last week from the effect of chloroform, which was being administered for the purpose of operating on fistula. No details are forthcoming as to the mode of administering, or the quantity of the drug inhaled.

Increase in Vaccinations.

THE returns of successful vaccinations performed in Bethnal Green for 1899 contrast favourably with those

of the preceding year. In 1898 there were 646 vaccinations and the fees amounted to £248, but since the new Vaccination Act came into force the number has gone up to 2,027 at a cost of £865.

Death of a Medical Cyclist.

DR. KENT, of Sheen Road, Richmond, was run down by a van in Richmond Road, Twickenham, on Wednesday of last week, and sustained injuries to which he ultimately succumbed. The occurrence was purely accidental, and the jury exonerated the driver from blame.

The New Medical Society.

AT the meeting held last week in London under the presidency of Dr. A. G. Sansom, it was formally decided to found a society devoted to the study of the diseases of children. Mr. Clement Lucas, in an eloquent speech, pointed out the value of such a society, and moved that it was desirable to form an association of the kind. The resolution was seconded by Dr. Fletcher Beach and carried unanimously. The honorary secretary for the time being is Mr. Sydney Stephenson, of 33, Welbeck Street. There can be no doubt as to the useful field of work that lies open to the Society, to which we offer our cordial wishes for future prosperity.

London School of Medicine for Women.

THE Helen Pridaux Memorial Scholarship, value £50, will be awarded in July, 1900, to a graduate of the London School of Medicine for Women (Royal Free Hospital). Candidates must be registered medical women of not more than three years' standing on June 1st, 1900, and must send in to the trustees, under cover to the Secretary, an essay on some medical subject, on or before July 15, 1900. The subject chosen by each candidate may be connected with any department of medical or surgical practice. In estimating the relative value of the essays the trustees will attach special value to the evidence afforded of clinical work and of direct and personal experience.

PASS LISTS.

Royal College of Surgeons of England.

THE following members having passed the necessary examinations, have been admitted Fellows of the College in the order of their seniority as Members:—

Thomas Richard Mulroney (Major I.M.S. Bengal), M.D. Malta, L.R.C.P. & S. Edin, Bombay and King's College, London, date of Membership, 1880; Frederic Victor Milward, M.B., B.C. Cantab., L.R.C.P. Lond., Cambridge University and St. Thomas's Hospital, Member, 1895; Hugh Mallinson Rigby, M.B., B.S. Lond., L.R.C.P. Lond., London Hospital, Member, 1895; John Shields Fairbairn, M.B., B.Ch. Oxon., L.R.C.P. Lond., Oxford University and St. Thomas's Hospital, Member, 1895; Louis Bathe Rawling, M.B., B.C. Cantab., L.R.C.P. Lond., St. Bartholomew's Hospital, Member, 1896; Stephen Frederick Lynch, L.R.C.P. Lond., King's College Hospital, Member, 1897; Malcolm Goodworth Dyson, L.R.C.P. Lond., St. Bartholomew's Hospital, Member, 1897; Donald John Armour, M.B. Toronto, M.R.C.P. Lond., University College, London, Member, 1897; William Douglas Harmer, M.B., B.C. Cantab., L.R.C.P. Lond., St. Bartholomew's Hospital, Member, 1898; Walter John Henry Hislop, M.B., C.M. Edin., L.R.C.P. Lond., St. Bartholomew's Hospital, Member, 1898; Herbert Sherwell Clogg, M.B. Lond., L.R.C.P. Lond., Charing Cross Hospital, Member, 1898; Lawrie Hugh McGavin, L.R.C.P. Lond., Guy's Hospital, Member, 1898; Arthur Webb Jones, L.R.C.P. Lond., St. Thomas's Hospital, Member, 1899; Thomas Holmes Middlebro', M.B. Toronto, L.R.C.P. Lond., University of Toronto, Canada, and King's College, London, Member, 1899; and John Percy Lockhart Mummery, L.R.C.P. Lond., St. George's Hospital, Member, 1899.

Of the 32 candidates who presented themselves for this examination 15 passed and 17 were referred.

University of Cambridge.

The following degrees were conferred at the Congregation on June 7th:—

Doctor of Medicine.—L. Falkener, M.A., King's; A. H. Thompson, M.A., Trinity; W. J. Harris, M.A., Christ's.
Bachelor of Medicine.—N. J. McCaskie, B.A., and E. A. Wilson, B.A., of Caius; J. E. Linnell, B.A., of Selwyn.
Bachelor of Medicine and Bachelor of Surgery.—J. G. Taylor, B.A., King's; W. P. S. Branson, B.A., Trinity; C. E. Marriott, B.A., Clare; E. Cox, B.A., and W. M. Willoughby, B.A., Caius; H. G. Cooper, B.A., Emmanuel.
Bachelor of Surgery.—L. Falkener, M.A., King's; T. S. Taylor, B.A., King's; W. L. Ascherson, non-collegiate.

Notices to Correspondents, Short Letters, &c.

65 CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

THE INEBRIATES' ACT.

To the Editor of THE MEDICAL PRESS and CIRCULAR.

SIR, - I shall feel obliged if you or any of your readers can give me the address of an inebriate home, in which a patient can be received for a small payment—Midland counties preferred. Patient is willing to submit to the confinement necessary, but can only afford moderate payment.—Thanking you in anticipation,
I am, Sir, yours truly,
A COUNTRY PRACTITIONER.

[The only institution with which we are acquainted within easy distance of our correspondent is Buntingford House Retreat, Hertford. The terms here are 25s. per week with no extras. The Medical Superintendent is Dr. Norman Davis, to whom applications should be addressed.—ED.]

X. Y.—Marlioz is a southern suburb of Aix-les-Bains. In a handsome park at Marlioz there is a hydrotherapeutic establishment, with baths, douches, pulverisations, inhalation hall, &c. Marlioz has three mineral springs, yielding abundantly very strongly sulphurous sodic waters (slightly charged also with iodine and bromine) of about 57° Fahr. temperature. These Marlioz waters are successfully used in respiratory and uterine catarrhal troubles, skin diseases, chlorosis, anæmia, gout, and rheumatism. They are a very valuable adjunct to the Aix treatment.

A NEW DEFINITION OF PTOMAINES.

On the appeal in the famous Inns of Court food intoxication case Mr. Justice Smith defined ptomaines as "bacteria in an aggravated form." Though scarcely fitted to replace the definition which at present finds place in our text books, the description conveys a very fair idea of the effects, and is less wide of the mark than many a scientific pronouncement.

Meetings of the Societies and Lectures.

WEDNESDAY, JUNE 20TH.

ROYAL MICROSCOPICAL SOCIETY (20, Hanover Square, W.). - 8 p.m. Mr. W. Carruthers. Demonstration on the Structure of Some Palæozoic Plants (with sections of the plants thrown on the screen).

THURSDAY, JUNE 21ST.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.—5 p.m. Dr. F. W. Mott: The Degeneration of the Neurone (Croonian Lecture).—Lecture II.

ANATOMICAL SOCIETY OF GREAT BRITAIN AND IRELAND (Medical School of the Owens College, Manchester). 10.30 a.m. Exhibition of Specimens. 11 a.m. to 1.30 p.m. Lantern Demonstrations by Dr. B. J. Berry, Prof. Dixon, and Dr. T. H. Bryce. Cases and Specimens will be shown by Prof. Fawcett. Papers:—Prof. Birmingham: Some Points in the Anatomy of the Digestive System.—Dr. Armour: A Note on the Genital Apparatus of the Jerboa. Council Meeting.

FRIDAY, JUNE 22ND.

ANATOMICAL SOCIETY OF GREAT BRITAIN AND IRELAND (Medical School of the Owens College, Manchester).—10.30 a.m. Exhibition of Specimens. 11 a.m. to 1.30 p.m. Papers:—Dr. C. J. Patten: Note on the Configuration of the Heart in Man and some other Mammalian Groups. - Dr. P. Thompson: On the Arrangement of the Pelvic Fasciæ and their Relationship to the Levator Ani.—Prof. Paterson: A Preliminary Note on the Development of the Sternum. Specimens, Preparations, Lantern Slides, and Microscopical Preparations will be shown by Prof. Paterson, Dr. A. Robinson, and Prof. Young.

Appointments.

CODD, A. F. G., M.B.Durh., F.R.C.S.Eng., Certifying Surgeon under the Factory Acts for the Bromley District, Kent.
COURTENAY, K. J., L.R.C.P., L.R.C.S., L.F.P.S.Glasg., Medical Officer of Health for the Wareham and Purbeck Rural District.
CROSSFIELD, ARTHUR KYFFIN, L.R.C.P., L.R.C.S.Edin., Public Vaccinator for Dartmouth, Devon.
FLINT, J. B., L.R.C.P.Lond., M.R.C.S., Certifying Surgeon under the Factory Acts for the Buxton District, Derbyshire.
FREEMAN, JOHN, L.R.C.P.Lond., M.R.C.S., Civil Surgeon, Officer in Medical Charge of Troops at Plymouth.
HAYWARD, W. T., L.K.Q.C.P.Irel., M.R.C.S., Member of the Board of Management of the Adelaide Hospital, South Australia.
HIGGINSON, C. G., L.R.C.P.Lond., M.R.C.S., Assistant Medical Officer of the Infirmary for the Parish of Birmingham.
MUIR, J. S., M.B., C.M.Edin., L.R.C.P.Ed., Certifying Surgeon under the Factory Acts for the Selkirk District.
PONDER, C. F., M.B., Ch.M.Edin., Government Medical Officer and Vaccinator at Hillaton, New South Wales.
PRICE, S. E., L.S.A., Medical Officer for the Ninth Sanitary District of the Bromley Union.
ROBINSON, T. H., M.D.Ed., Ch.M., District Medical Officer at Albany, West Australia, and Public Vaccinator for the Urban and Suburban Districts of Albany and Rural District of Plantagenet.

ROPER, HENRY, B.A., M.B., R.C.Cantab., L.R.C.P., M.R.C.S., Deputy Medical Officer for Lynton, Devon.
SMITH, W. E. M.B., M.Ch.Edin., Honorary Physician to the Adelaide Hospital, South Australia.
THANE, E. H., M.D.Lond., L.R.C.P., M.R.C.S., Government Medical Officer at Wagga Wagga, New South Wales.
TREVOR-ROPER, G. D., L.R.C.P.Ed., L.F.P.S.Glasg., Medical Officer for the Masingham District of the Freebridge Lynn Union.

Vacancies.

Birmingham—City Hospital, Lodge Road.—Assistant Medical Officer. Salary £120 per annum, with board and residence.
Borough of Bootle Hospital for Infectious Diseases.—Resident Medical Superintendent. Salary £120 per annum, with board, washing, and apartment in the hospital. Applications to the Chairman of the Hospital Sub-Committee, Town Hall, Bootle.
City of London Asylum, near Dartford, Kent.—Assistant Medical Officer (*locum tenens*) for seven weeks. Terms three guineas a week.
County Asylum, Rainhill, near Liverpool.—Assistant Medical Officer. Salary commencing at £125 per annum, with furnished apartments, board, attendance and washing.
County Asylum, Whittingham, Lancashire.—Junior Assistant Medical Officer, unmarried. Salary commencing at £125 per annum, with furnished apartments, board, attendance, and washing.
Cumberland and Westmorland Asylum, Garlands, Carlisle.—*Locum tenens*. Terms three guineas per week, with board and residence.
Merthyr Tydfil Urban District Council.—Medical Officer of Health for five years. Salary commencing at £400 per annum, exclusive of out-of-pocket expenses. Applications to the Clerk, Town Hall, Merthyr Tydfil.
North Riding Asylum, Clifton, York.—Junior Assistant Medical Officer, unmarried. Salary commencing at £125, with board, furnished apartments, washing, and attendance.
Oldham Infirmary.—A Senior and a Junior House Surgeon for one year. Salary £85 and £70 per annum respectively, with board, residence, and washing. Also *locum tenens* for at least one month. Terms four guineas per week, with board and residence.
Plymouth Borough Asylum.—Assistant Medical Officer, unmarried. Salary commencing at £125 per annum, with furnished apartments in the Asylum, with board and washing.
Stamford, Rutland, and General Infirmary, Stamford.—House Surgeon for two years, unmarried. Salary £100 per annum, with board, lodging, and washing.
The Children's Hospital, Temple Street, Dublin.—House Surgeon. Salary 50 guineas per year, with apartments, fire, light, and attendance. Applications, with copies of testimonials, to Mr. C. Stanton, Hon. Sec., Medical Board. (See Advt.)
Wiltshire.—Outdoor Assistant in extensive practice. Salary £192 first year. Will not be required to dispense or keep books.
Address Medical Officer, New Swindon. (See Advt.)
Wolverhampton and Staffordshire General Hospital.—House Surgeon. Salary £100 a year, with board, lodging, and washing.

Births.

BROWN.—On June 15th, at Fairlie House, Malden, the wife of Henry Reynolds, M.B., C.M., of a son.

Marriages.

BALLARD—COMBE.—On June 12th, at St. Mary's Church, Chester, Robert Ballard, M.R.C.S., L.R.C.P., youngest son of the late Edward Ballard, M.D., F.R.C.P., F.R.S., to Beatrice, youngest daughter of the late James Combe, of Ormiston, co. Down, J.P., and Mrs. Combe, of Glean Aber, Chester.
LONG—BEADLES.—On June 12th, at Christ Church, Forest Hill, John Reginald Long, M.R.C.S., L.R.C.P., son of Arthur Long, M.R.C.S., of Dover, to Henrietta Annie, eldest daughter of Arthur Beadles, M.R.C.S., of Forest Hill.
SWEEL—REID.—On June 14th, at the Roxburgh Hotel, Edinburgh, by the Rev. Alexander Badenoch, M.A., Ernest Hugh Sweel, M.D., B.Sc., of Coventry, to Mary Katharine, second daughter of the late William Reid, of Dunfermline, N.B.
STUART—DUTTON.—On June 14th, at St. Bartholomew's Church, Sydenham, Walter Lea Stuart, M.R.C.S.Eng., L.R.C.P.Lond., son of the late J. E. Stuart, Esq., of Hampstead, to Katharine Eleanor, daughter of the late Rev. A. Dutton, formerly Vicar of West Hyde, Rickmansworth.

Deaths.

ALTHAUS.—On June 11th, at Queen Anne Street, Cavendish Square, London, Julius Althaus, M.D., M.R.C.P.Lond., aged 67 years.
ARGLES.—On the 14th inst., at 74, Oxford Terrace, Hyde Park, London, suddenly, of angina pectoris, Robert Argles, L.R.C.P., aged 60.
BRYANT.—On June 7th, at Bloemfontein, South Africa, from enteric fever, Hugh A. Bryant, aged 33, M.R.C.S., L.R.C.P., Civil Surgeon, Royal Army Medical Corps, and late of Shaftesbury, third son of Thomas Bryant, F.R.C.S., M.Ch., of 65, Grosvenor Street, W., Consulting Surgeon to Guy's Hospital, and Surgeon Extraordinary to H.M. the Queen.
EDWARDS.—On June 6th, at Felixstowe, George Cordy Edwards, M.R.C.S., late of Ipswich, in his 81st year.
LIGHTFOOT.—On June 5th, at Saville Place, Newcastle-on-Tyne, suddenly, Charles L. Lightfoot, M.D., M.R.C.S., aged 38 years.
MERRYWEATHER.—On June 11th, at Guisborough, Yorkshire, James Merryweather, M.R.C.S., aged 68 years.
WILLIAMSON.—On June 6th, at Eldon Square, Newcastle-on-Tyne, George Edward Williamson, F.R.C.S.Eng., aged 48 years.

The Medical Press and Circular.

"SALUS POPULI SUPREMA LEX."

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WEDNESDAY, JUNE 27, 1900.

No. 26

ABSTRACT OF THE Cabendish Lecture ON THE APPLICATION OF PATHOLOGY TO SURGERY. (a)

By HENRY T. BUTLIN, F.R.C.S., D.C.L.,
Surgeon to St. Bartholomew's Hospital.

DURING the time I was house surgeon at St. Bartholomew's Hospital, my master, Sir James Paget, said one day that he could not understand how men could say that a knowledge of pathology was of no use in surgery. He desired to impress on us, then and always, that pathology is the foundation of surgery; and of course we believed him. We believed everything which Sir James Paget said; and if he had made botany or mathematics the foundation of surgery, we might not improbably have equally accepted the statement. But the foundation of surgery on pathology seemed so reasonable a proposition as to be almost self-evident, and the more I thought of it the more I wondered, too, how surgeons could be blind to the advantages of a knowledge of pathology. When at a later period the science of applied pathology was before my mind, I began to consider the various relations of pathology to surgery, and in what various ways surgery may be indebted to pathology. Three relations instantly occurred to my mind. The knowledge of the pathology of a disease may explain the manner in which an operation acts. Or, it may lead to the development and improvement of an operation which has previously been practised by a kind of rule of thumb. Or, a thorough knowledge of the pathology of a disease may precede and lead to the deliberate invention of an operation or method of treatment for its relief or cure. The third of these relations is so much higher in its kind than the two first that I determined to collect striking instances of it. And to render the study more easy, I divided it into two periods of time, past and present, and carried the past up to, and the present back to, about thirty-five years ago. The period of the present almost coincides with my own recollections of surgery; but it was not on that account alone that the division was made. About thirty or thirty-five years ago scientific training and methods began to be slowly appreciated, and, in consequence, a great change of method and study gradually took place.

THE PAST.

Both years ago, and again lately, I read old books on surgery, and books on the history of surgery; and as my own time for such reading has of late been limited, I obtained the assistance of Mr. Henshaw, who is admirably fitted for this kind of study; and I prepared, not only my mind, but my pen and paper to record the pleasant impressions I

should receive from the account of the inventors and discoverers themselves, or of their trusty friends and biographers, of the manner in which new inventions and discoveries in surgery had been made, or in which inventions had been developed and improved. The subject would be likely to derive a special charm, which is seldom felt in the study of general inventions. There is no question here, of patents and of large fortunes, only of honour and of the advancement of a noble profession, which performs its work for the benefit of suffering humanity. There would not, therefore, be such an exhibition of human selfishness and greed. And the inventors of surgical methods would but rarely be treated with the same cruelty which has, in all ages, been meted out to the authors of general inventions. What contemplation, then, could be more agreeable than that of the great surgeon of the past sitting in face of some weighty problem, working out slowly and with difficulty the pathology of some serious malady, and then building up his treatment against the disease? or founding a new and admirable operation for the relief of some terrible surgical malady on a knowledge of the pathology which had been worked out by other hands and heads.

Inventions in surgery have probably been made much in the same manner as general inventions; and have owed more to accident, to observation, to comparison and to deduction, than to pathology. Paré's invention of the ligature may be taken as an example of the influence of accident, if inspiration can be regarded as an accident. Pondering over the brutality of the arrest of hæmorrhage by the cautery, and having dimly in memory a sentence in Galen, his mind is suddenly illuminated with the idea of tying the bleeding ends of the vessels. A less bold surgeon would have shrunk from attempting the experiment on the human subject. Not so Paré. On the first opportunity he applies ligatures to the vessels in a recent wound. The experiment is a success; it is repeated, extended to the vessels cut in amputation, and is then recommended to the world of surgery.

The more elaborate operations have probably been the work of several or of many men, each of whom has added a little towards the perfection of the operation. A curious instance of this complex manner of invention of a new treatment is afforded in Mr. Pott's tracts on "Palsy of the Lower Limbs, with Curvature of the Spine." (a) Pott introduced to the profession the method of treating this affection by means of copious discharge of matter from the adipose tissue at each side of the curvature. He formed a large issue on either side of the spine by means of caustic, filled the grooves left by the separation of the eschars with several peas, and even applied from time to time cantharides, ærugo, æris, and other irritants, to maintain or increase the discharge until the patient had completely recovered the use of his legs. Pott was so convinced of the value of this

(a) Delivered before the West London Medico-Chirurgical Society, on Friday, June 22nd, 1900.

(a) London, 1779

method of treatment that he wrote a second tract (a) in favour of it about three years after the first. With his characteristic sincerity he admitted that the idea was not his own, but had been recommended to him by Dr. Cameron, of Worcester, who said "that he remembered, some years ago, to have noted a passage in Hippocrates, in which he speaks of a paralysis of the lower limbs being cured by an abscess in the back or loins, and that taking the hint from this, he, Dr. Cameron, had in a case of a palsy of the legs and thighs, attended by a curvature of the back bone, endeavoured to imitate this act of nature by exciting a discharge near the part, and that it had proved very advantageous." In the same tracts in which he urges the employment of this very doubtful method of treatment, Pott gives an admirable description of the morbid anatomy and pathology of caries of the spine; so that here is an instance of what we should regard as a bad treatment, introduced by Pott, who was thoroughly acquainted with the pathology of the disease, and resting on a false deduction by Cameron, of the effects of a fact observed by Hippocrates

THE PRESENT.

In the early years of the second half of the nineteenth century there was little change in the relation of pathology to surgery. There was little teaching of pathology; and it would have then seemed very improbable that a new system of surgery would shortly be founded on pathology. I have elsewhere sketched the condition of the study of pathology about the year 1850, (b) especially in Great Britain, and have shown how small a hold it had yet taken on the minds of teachers or students. Yet there were, even then, signs of approaching change, and the most advanced and enlightened teachers were beginning to found their teaching of medicine and surgery on a more scientific basis. I have little doubt this was part of a general movement in favour of scientific training which began about the fifties and early sixties, which questioned the propriety of the old methods of general education, and desired to see them replaced, either in whole or in part, by science teaching; and which has since found its expression in technical and science schools, in laboratories, in science scholarships and prizes. The art of medicine could scarcely fail to feel the influence of this general movement, but the new leaven would probably have been very slowly infused into the teaching of our profession had not an event occurred which revolutionised the practice of surgery, and did more in a few years to lay the foundation of surgery on pathology than had been done in as many previous centuries. In the years 1867 and 1868, there appeared in the *Lancet* and *British Medical Journal* the first papers by Professor Lister on the subject of antiseptics, and his is the next great example, after Hunter's, of the discovery of a pathology and the invention of a treatment by one and the same individual. My own recollection of its early application in London is almost ludicrous. In 1868, I was house surgeon to Mr. Paget (afterwards Sir James Paget). We happened to have in the wards a man, about 40 years of age, with caries of the spine and a large abscess in the back. The results of the treatment of such cases were in those days lamentable, and the man was left for some days in bed untreated. But one afternoon Mr. Paget came down and said he would try a new method of opening and treating the abscess, which had been suggested by a surgeon in Edinburgh, called Lister. A few days later we opened the abscess under the direction of Mr. Paget, through a piece of lint soaked in some antiseptic, and then applied a little mass of antiseptic

putty, about half the size of my fist, over the opening, and a piece of sheet lead upon the putty. That day and the following days the dressings frequently slipped down and was found half a foot or more below the wound. And in the course of a few days the cavity of the abscess became septic and the patient died, as many of those who were suffering from similar conditions did in those days.

In these days, the news of successful treatment travels fast, so fast, indeed, that a new method is sometimes accepted and adopted before it has been proved by the inventor. Such is the progressive spirit of the age, and so abundant and so excellent are the media of communication. Of course, these are great advantages, but there is still no trace of any distinct organisation for the application of pathology to surgery. Indeed, in some respects, things are likely to be worse than they were some twenty years ago. As pathology becomes more specialised, the surgeon and the pathologist must necessarily be more widely separated; and although the surgeon may make great use of the pathologist in his wards, they are no longer one and the same person. Problems in pathology and in the relation of pathology to surgery will arise in the minds of the men who have not the time or the knowledge to work them out, and who know not how or by what means to get them worked out. On the other hand, those who work at research may know nothing of the questions which occupy the minds of surgeons. On this account many problems quite worth the working may be wholly neglected, or their study long deferred.

If we are to remedy these defects, it can only be by some more perfect organisation, such as may perhaps be supplied by my science of applied pathology. Great attention has been devoted to pure pathology, and pains have been taken to educate and train discoverers. Laboratories for research are provided for them; materials and instruments are furnished; directors of distinguished ability and of approved skill in research are appointed. In consequence, the work of discovery proceeds apace. The more original and the abler workers choose their own subjects of research, and make their discoveries in their own way and in their own time. Those who are not so original and able are assisted in their researches by the directors.

But while our schools for discoverers are good and are improving, we have no school for inventors, for the men who are to make the applications of pathology in the future. It is on that account I venture to urge the importance of the science of applied pathology, which may prove a fitting school for inventors, as the science of pure pathology is for discoverers.

There are in this town at the present moment laboratories where researches in pathology are constantly carried out, and some of these laboratories are quite separate from and independent of the hospitals. There is an institution of preventive medicine, where pure and applied pathology are studied, but this is also separate from the hospitals. During the last few years several of the hospitals have founded professorships of pathology and have appointed to them men who devote to the science of pathology not merely the time they can spare from some other pursuit, but their whole time. These men are constantly in touch with the work of the wards, and furnish the greatest assistance to it by bacteriological and histological examinations. Speaking of my own hospital, the assistance rendered to the work of the wards by Dr. Andrewes and his predecessor, Dr. Kunthack, has been of inestimable value. Indeed, it is difficult to understand how we could have performed our work efficiently before the institution of the pathological laboratory.

(a) London, 1712.

(b) Address on the Jubilee of the Pathological Society of London October 20th, 1896, *Pathological "Transactions,"* Vol. XLVIII.

But although the last few years have seen a very great improvement, much remains to be done. Money and organisation are necessary if great results are to be secured. The laboratories for research in pure pathology are too small and too scattered, and insufficiently endowed. The laboratories in the hospitals which ought to be devoted to applied pathology are used for every kind of microscopical and bacteriological examination and for teaching, so that research is crowded out. And pathological chemistry, from which vast things are to be hoped in future, has taken no proper hold upon the town.

Happily there is reason to hope that the changes which must take place in connection with the new teaching university will be greatly to the advantage of pathological research, especially in connection with the hospitals. The removal of the teaching of the preliminary subjects to large central establishments will afford space for the expansion of the pathological departments. And as the value of applied pathology becomes more evident, funds will easily be found in this rich town for its development.

The question has several times suggested itself to me whether a number of men thrown together in the laboratories for research and for invention are likely to do better or worse for coming into contact. So far as discovery is concerned there is every reason to believe that a community of workers is likely to do more and do it more quickly than the same men working separately and in ignorance of each other's work. Assistance and suggestion must come from community. But the advantages of community for invention may be contested. We have been so much accustomed to the picture of the inventor working in solitude, and often in secrecy, that the idea of a number of inventors at work openly and in communion with one another seems almost repugnant. But there seems no reason to doubt that the advantages which discoverers might gain from community would be equally gained by the inventors, and there can be little doubt that the solitude and secrecy in which the inventors of methods and machines for industrial purposes have generally worked were imposed on them by the necessity of guarding their inventions from the public eye.

At the present time I am told that the advantages of the community of workers in research are to be seen in the laboratories attached to some of the great industrial establishments in Germany, particularly to the colour industries. From 50 to 100 chemists are continually employed in some of these establishments, where they work in magnificent laboratories, furnished with all the apparatus which is needed for original research, and presided over by the most distinguished professors who can be obtained. The laboratories are intended for research, and I understand that the scope of the research need not be restricted to the needs of the particular industry to which the laboratory belongs, but that original research of every kind in chemistry is encouraged. The cost of such laboratories is extremely large, for the salaries of the workers are said to be on a very liberal scale. And some of the researches which occupy weeks or months of the time of the workers, and of the space and accessories of the laboratory, are of no direct use to the industry. Yet the industry, which is proprietary, and not the property of the State, or founded for the advancement of chemical science, derives so much advantage from a certain percentage of the discoveries and applications made in the laboratories that the funds expended on them are well laid out. Those Englishmen who are familiar with these establishments tell me that this investment of funds in scientific research has served to place the German colour industry far ahead of our own.

We want something of the same kind for the advancement of medicine and surgery, a direct and

organised scheme for research and the application of pathology to our art. Of the advantage which may be derived from it I have no doubt. And if we fail to obtain it it is because our forces are too divided and our views are not sufficiently in harmony. To those who think that the necessary funds would not be forthcoming the answer must be that very considerable sums of money have, during the last few years, been devoted to medical research, and that the public mind is gradually becoming alive to the advantage to the nation of good health and the preservation of life.

INDICATIONS FOR THE REMOVAL OF THE UTERINE APPENDAGES. (a)

By J. BLAND-SUTTON, F.R.C.S.,
Surgeon to the Middlesex Hospital, &c.

I WAS greatly interested in Dr. Macpherson Lawrie's very practical paper which appeared in THE MEDICAL PRESS AND CIRCULAR (May 30th, 1900). It is important to observe how much the operation has become limited in the last five years. From the beginning of my surgical career I have always acted upon one rule, never to remove Fallopian tubes and ovaries unless there was very tangible evidence of disease in these structures. Increased experience has taught me to limit the removal of tubes and ovaries to two sets of conditions, namely, inflammatory lesions and tubal pregnancy.

Under the title of inflammatory lesions of the tubes and ovaries I include *chronic* salpingitis secondary to septic endometritis, whether due to gonorrhœa or septic infection occurring as a sequel to labour or abortion, and tuberculosis of the tubes. Chronic salpingitis calls for operative treatment in three forms:—(1) the large thin-walled and often stinking pyosalpinx; (2) the sclerosed tube closely adherent to or actually communicating with a small cyst or abscess in the ovary (tubo-ovarian abscess); and (3) the thin-walled hydrosalpinx. These three groups of inflammatory tubal disease are the commonest conditions for which double oöphorectomy is required, and they constitute three-fourths of the cases in Dr. Macpherson Lawrie's list.

I requested Dr. Victor Bonney, who has acted for more than two years as the resident medical officer at the Chelsea Hospital for Women, to draw up a list of the cases in which I have performed oöphorectomy since I was appointed surgeon to that institution.

The total number from November, 1895, to the end of May, 1900, amounted to 94. The majority of these operations have been undertaken for the consequences of septic infection occurring as a sequel to endometritis, set up by gonorrhœa or due to sepsis following labour at term or a miscarriage, and 12 were performed for tubal pregnancy.

I have made a comparison of the proportion of cases of infective tube disease in hospital and in private practice. It is remarkable that in the hospital the proportion of tubal cases is three times greater than in private practice, and this I believe to be due to the following causes:—Harlots take less care of their genitals than well-to-do courtesans, and the wives of the poor do not receive the same careful obstetric nursing as the wives of the rich.

In regard to the value of oöphorectomy in neurotics I cannot say anything for I have never operated under such conditions, and a study of the remarkable "symposium" published in 1886 by Spencer Wells, Hegar, and Battey has satisfied me

of the futility of the proceeding. I also strongly deprecate removal of the ovaries for dysmenorrhœa. The fact that gynecologists realise that the ovaries fulfil other duties than supplying ova has induced operators to be still more careful in regard to the complete removal of ovaries. I do not believe that gynecologists fully realise how difficult it is to completely remove inflamed ovaries, and I have demonstrated on several occasions where it has been necessary to perform a second operation, the stump left after the primary oophorectomy to be surmounted by a rounded piece of ovarian tissue which contained follicles and clearly fulfilled ovarian functions for it contained corpora lutea. This might help to explain some of the few anomalous cases where an operator believes that he has completely removed both ovaries yet the woman subsequently becomes pregnant.

I am surprised that Dr. Lawrie advocates the removal of the ovaries for the relief of uterine fibroids, for that operation, like the still more unsatisfactory one of double oophorectomy for the relief of mammary cancer, is rapidly being banished from the domain of legitimate surgery. I feel a certain amount of pride in stating that the numerous consecutive abdominal oophorectomies (of which I supply a table) were performed without a death, and I believe that I owe this success to thorough asepsis, abstention from irrigation, and the substitution of a narrow strip of sterilised gauze for the drainage tube. In three of the cases in the table the tubes, ovaries, and uterus were so bound together that it was necessary to remove the uterus. In a great number of the cases the purulent contents of the tubes were submitted to careful bacteriological examination. In a large majority of the specimens the pus was sterile, but it came out very strongly in the inquiry that, although the pus was free of micro-organisms, these little bodies were often found scattered in the tubal tissues. My results in private practice have been as good as those at the Chelsea Hospital for Women, but I have restricted the table to hospital cases, as they can be easily verified.

Dr. Victor Bonney has drawn up for me a table of ninety-four consecutive operations for chronic salpingitis, pyosalpinx, hydrosalpinx, tubercular salpingitis, and tubal pregnancy, performed by me at the Chelsea Hospital for Women.

1895.		
Oct. 18,	J. K., 34	Bilateral chronic salpingitis.
1896.		
Feb. 2,	M. S., 18	Leaking pyosalpinx.
April 13,	C. P., 25	Double pyosalpinx.
" 20,	M. H., 39	Gravid left tube.
" 27,	A. F., 27	R. hydrosalpinx.
May 5,	E. C., 25	Gravid left tube.
" 21,	A. W., 42	Warty sclerosed ovaries.
June 15,	S. R., 40	Left pyosalpinx.
July 6,	B. B., 17	Tubercular tubes (?)
" 3,	F. G., 27	Sclerosed tubes.
" 17,	S. C., 24	Gon salpingitis.
" 19,	M. C., 45	Left gravid tube.
Oct. 26,	A. C., 24	Right inflamed tube and ovary.
Nov. 2,	A. E., 37	Inflamed tubes.
1897.		
Jan. 4,	H. M., 29	Left pyosalpinx.
" 25,	C. D., 32	Left hydrosalpinx.
Feb. 15,	E. H., 27	Double hydrosalpinx.
" 15,	G. K., 23	Double pyosalpinx.
March 1,	M. S., 28	Cystic right ovary.
" 8,	F. W., 19	Right tube and ovary. Tubercular.
May 10,	M. G., 18	Double oophorectomy; tubercular tubes.
July 2,	A. H., 26	Double gon. salpingitis.
" 5,	E. B., 33	Sclerosis of both ovaries and tubes.
" 12,	E. C., 42	Double pyosalpinx.
Aug. 27,	M. S., 34	Double hydrosalpinx.

Sept. 2,	C. W., 23	Double tubercular salpingitis.
" 6,	E. W., 38	Gravid left tube.
Oct. 4,	C. B., 30	Cystic and prolapsed right ovary.
Nov. 2,	E. H., 34	Right pyosalpinx.
" 29,	A. C., 33	Right hydrosalpinx.
Dec. 6,	B. B., 35	Double salpingitis.
1898.		
Jan. 3,	L. S., 23	Right gravid tube.
" 3,	E. S., 38	Right oophorectomy and cyst of broad ligament.
" 10,	E. M., 45	Right salpingitis and pedunculated fibroid.
" 17,	M.,	Left oophorectomy.
" 31,	C. D., 27	Right salpingitis.
Feb. 10,	G. H., 25	Right gravid tube.
March 14,	M. R., 38	Right sclerosed tube, Left tube removed by Lawson Tait.
" 21,	O. P.,	Right gravid tube.
April 4,	B. I., 25	Right gravid tube.
May 2,	M. W., 40	Huge pyosalpinx uterine fibroid. Hysterectomy also performed.
" 2,	E. S., 24	Right gravid tube.
" 9,	S. S., 26	Removal of painful stump after oophorectomy. The fragment of the ovary was cystic and contained a corpus luteum.
" 9,	E. G., 58	Double oophorectomy. Right ovary contained a calcareous ball.
" 30,	E. P., 23	Left oophorectomy for salpingitis.
June 8,	E. S., 33	Sclerosed ovary; hysteropexy.
" 13,	M. T., 35	Left pyosalpinx and suppurating cyst of left broad ligament.
" 31,	E., 35	Double pyosalpinx.
" 20,	H. R., 30	Large bilateral pyosalpinx.
July 1,	J. M., 39	Double salpingitis. Double oophorectomy and hysterectomy was necessary.
" 4,	K. G., 24	Tubal pregnancy.
" 11,	M. A., 39	Double oophorectomy: a pedunculated fibroid was also removed.
" 25,	C.,	Left oophorectomy and hysteropexy.
Sept. 3,	H. W., 27	Double pyosalpinx.
" 19,	L. K., 32	Left salpingitis.
Oct. 10,	J. D., 25	Right salpingitis.
1899.		
Jan. 16,	L. C., 29	Left salpingitis and prolapsed ovary.
" 23,	M. P., 26	Cystic right ovary.
Feb. 13,	G. F., 32	Double pyosalpinx.
" "	E. C., 44	Gravid tube.
" 20,	M. L., 22	Left pyosalpinx.
" 27,	E. C., 29	Bilateral sclerosed tubes.
March 3,	S. B., 37	Double oophorectomy, chronic abscess in each ovary
" 27,	M. H., 21	Double pyosalpinx
April 24,	A. G., 40	Right salpingitis and enucleation of a fibroid
" 24,	M. H., 26	Bilateral pyosalpinx.
May 8,	M. C., 38	Salpingitis (bilateral)
" 15,	E. K., 38	Double pyosalpinx and hysterectomy for septic uterus.
" "	K. N., 34	Double salpingitis.
" 29,	A. D., 33	Double salpingitis.
" 29,	C. G., 28	Huge left pyosalpinx and hysterectomy to stop the bleeding.
June 12,	E. C., 45	Bilateral pyosalpinx.
" 12,	S. R., 33	Sclerosed tubes.
" 26,	A. B., 29	Bilateral tuberculous salpingitis.
Nov. 6,	E. P., 23	Left cystic ovary and ventrofixation.

Salpingitis and cyst in left ovary.
 Right salpingitis.
 Left salpingitis. R. ovariotomy.
 Double tuberculous salpingitis.
 Left salpingitis.
 Bilateral salpingitis.
 Left salpingitis.
 Double pyosalpinx.
 Tuberculous salpingitis (lateral).
 Sclerosed tubes.
 Double pyosalpinx.
 Left gravid tube.
 Double salpingitis.
 Double salpingitis.
 Double salpingitis (tuberculous).
 Huge bilateral hydrosalpinx.
 Double pyosalpinx.
 Right hydrosalpinx and left tubo-ovarian abscess.
 Removal of stump left after double oophorectomy. Hysterectomy.

LE MENINGITIS. (a)

VERS SMITH,

Hardwicke Hospital, &c., &c.

cases of cerebro spinal of a doubtful nature in the year, and five other cases of Dr. O'Carroll in the are the points on which diagnosis in future cases:—
 rred for certain in nine of others no history could in the head and vomiting: ent in nine on admission; subject to exacerbations, al than occipital. Retracted neck, which gave pain on as present early in eleven

The pulse was slow, even rather high, in eight of first week. Loss of knee at time of admission to e cases; in one it was aggerated. Conditions of hat irregular, responding rity of cases. Four of the anges in the optic disc. urteen cases had eruptions on were an erythematous e erythematous eruption all-defined edges, felt very ood many days. It was out in one case it appeared on the breast and down he herpes appeared most neck. In two cases there he feet. In only one case ne classical description of nt died on the seventeenth ath these spots appeared were not well marked. I only in children. Later e sign was the irregular efinite type. Emaciation e fact that they got more y than typhoid patients.

Medicine in Ireland, May 18th,

Decubitus was also important. The stupor was not, I think, easily to be mistaken for that seen in other fevers. There was a tendency to intermissions and exacerbations. In all the cases which showed this, a rise in temperature was preceded by headache and vomiting. When these exacerbations occurred the temperature rose. In two cases I have seen hyperæsthesia of the skin of the neck. The subjective sensory symptoms were great pains in the back and down the spine, and in the legs as far as the knees. In some cases of rigidity of the neck only the deeper muscles were engaged, the trapezius being quite soft. I have not seen any great arching of the back. Of the fourteen cases nine were females. The duration was variable. One case, not yet quite well, had already lasted seventy-seven days; one proved fatal on the eightieth day, and one, which recovered, lasted seventy-three days. One patient died within a day-and-a-half. Four of the fourteen cases died; two patients came from the same house. The only sequela was permanent deafness in one case, and this without apparent otitis media. In two cases the patients, although recovered for some weeks, have involuntary micturition at night. The prognosis as regards recovery is exceedingly difficult. Some of apparently the worst cases recovered, while, on the other hand, two had suddenly become comatose and died within an hour, one on the seventeenth, the other on the second day. All were under twenty years, except in the case of one woman, aged thirty-six, who died

SUPRA-PUBIC LITHOTOMY.

By WM. ALEX. MACKAY, M.D.Ed., MCh., F.R.C.S.Ed.,

Huelva, Spain.

Translated from *El Siglo Médico*, by Dr. GEORGE FOY.

SUPRA-PUBIC lithotomy is indicated in the following conditions:—

1. Encysted calculi.
2. Large, hard calculi, with prostatic enlargement,
3. For the extraction of certain forms of foreign bodies.
4. When irritability exists to such an extent as to interfere seriously with lithotripsy.
5. As the first stage in prostatectomy.
6. For tumours of the bladder.
7. For tuberculosis of the bladder.
8. For pathological conditions requiring prolonged drainage.

9. Vesical conditions of uncertain nature but producing acute pain. The following are illustrative cases:—

(a) M. de la C., æt. 59, admitted to hospital November 2nd, 1890. He had undergone the crushing operation a year previously. At the end of twelve months he found his condition as bad as before. He was now cut by the high operation for stone, and six calculi removed, the largest being the size of a pigeon's egg. They weighed 260 grammes, and were principally composed of phosphates. For the past nine years the patient has enjoyed good health, there being no return of the disease.

(b) Castillo, æt. 75, admitted January 4th, 1892, had been submitted to the crushing operation in 1887. A year afterwards the symptoms of stone returned. Passing the catheter was very painful to him. He urinated every ten or fifteen minutes day and night. Examination revealed an enormous enlargement of the prostate. The urine was muco-purulent. The high operation was performed and a small phosphatic calculus removed. A glass drainage tube, which he still wears, was inserted, and to-day he enjoys good health at 83 years of age.

(c) M. F. P. de B., æt. 9, admitted February 24th, 1888. He complained of symptoms of stone for the past six years. On sounding, the clear sound of the calculus was got, and the lateral operation was decided on. But when the operation was about to begin no stone could be found by the sound; the conclusion arrived at was that the stone was encysted, and that the high operation

should be performed. On opening the bladder the stone was found enveloped in a large clot of blood. It was found to consist of oxalate of lime, and it weighed 63 grammes.

(d) Petra M. L., *æt.* 20, admitted November 22nd, 1892, suffered from pyrexia, cystitis and severe vesical pains. His health was so run down that he looked as if in the last stage of consumption. His pulse was from 120 to 130, and his temperature was 103° F. The crushing operation was decided on, but so great was the size of the stone and so hard was its texture that the lithotrite was not sufficiently strong, and instead of crushing we simply scraped off some of the outer layer of the stone. We were also interfered with by strong contractions of the viscous. The operation had to be discontinued. On the following morning the high operation was performed, and the calculus which principally consisted of uric acid and weighed two ounces was removed.

(e) M. G. de Campofio, *æt.* 75, was admitted on February 15th, 1894, complaining of the usual symptoms of stone. His bladder was found to contain not more than two ounces of urine; withal the high operation was decided on, and a mixed calculus of urates and phosphates, weighing 40 grammes removed.

(f) A. G. de Huelva, *æt.* 75, admitted May 30th, 1898. For the first year his urine was drawn six times a day. Blood was frequently found in the urine. Rectal examination detected a large prostate.

The patient complained of great vesical pain and a desire to pass water every minute. The high operation was performed, and on cutting into the bladder the enormously enlarged prostate projected into the wound.

For a week after the operation blood, pus, and mucus were passed in the urine. A large glass drainage-tube was fixed in the wound, and the bladder was washed out several times a day; the boric solution being injected through the urethra and escaped through the drainage-tube. This treatment was continued for two months, at the end of which time the patient left perfectly cured.

(g) A. H. J. F., a strong man, *æt.* 72, admitted on May 6th, 1899. For two years he had been suffering from symptoms of stone. He had hypertrophy of the prostate, yet his urine was healthy. He gave an unusual symptom—to wit, when lying in bed, as he turned from side to side, he found the stones to fall down to the lower side of the bladder. The supra-pubic operation was performed, and on trying to grasp the calculi some difficulty was experienced from the polished smoothness of the two calculi. They were of a yellowish-green colour, polished, as of crystal. They were of cystine, and weighed one ounce each.

(f) L. D., de Neros, *æt.* 55, admitted July 27th, 1899. For six years he has had all the symptoms of stone in the bladder; for the past six months the pains were dreadful. He was constantly urinating, and the act was acutely painful every time. On the advice of Drs. Salado, of Seville, and Macdonald, of Riotinto, the supra-pubic operation for stone was performed. The patient was very fat, the bladder very small, not containing two ounces of fluid; and as a result the wound was very deep. The perivisceral veins were unusually large and numerous. The day was one of the hottest, the thermometer marking 104° Fahr. in the shade. A quantity of blood filled the wound and obscured the view. Under the circumstances it was decided to plug the wound with gauze and complete the operation some other day. The patient was accordingly put to bed and kept there until July 30th, when he was again placed on the operation table; the gauze was removed, disclosing a clean dry wound. The bladder was opened, and a large uric acid calculus, weighing two ozs., was removed. The patient made a rapid recovery, and is now following his usual occupation.

The operation is practically unattended with risk—it more readily allows of the removal of the calculus than the perineal operations do; it allows of the bladder being examined thoroughly, and should be adopted in all cases except those in India, where the religious convictions interfere with the performance of any cutting operation.

Clinical Records.

A CASE OF FIBRO-MYOMA OF UTERUS. (a)

By DR. NEWNHAM.

THE weight of this specimen is 14 lbs, 11 ounces. The patient was a woman, *æt.* 24, who has been married for four years, but had had no children. The catamenia commenced at the age of 15, were always very profuse, lasting seven days, and the patient had to spend seven days in each month in bed. She had only noticed this tumour for two years. On admission to the hospital Dr. Newnham found that she had a large solid tumour filling up the abdomen, and reaching up to the ensiform cartilage.

On May 8th, 1900, he removed the tumour by intra-peritoneal hysterectomy; he had no difficulty except that he could not tie the uterine arteries until he had removed the tumour. She did not have a single bad symptom, the next morning (or 24 hours after the operation) she was reading a book in bed. She was discharged from hospital well on June 5th, 1900, or 28 days after the operation.

TWO DERMOID OVARIAN TUMOURS. (a)

By DR. ELDER,
Of Nottingham.

THESE specimens were removed from a patient, *æt.* 29, on May 14th, 1900. She had recently been married, and was seized with severe abdominal pain and fainting on March 27th, and had to be carried to bed, where she remained mostly till the date of operation. She developed symptoms of peritonitis, for which her medical attendant employed hot applications, blisters, opium, &c., with but little effect. When seen by Dr. Elder she had a somewhat tympanitic belly with free fluid, great tenderness, rapid pulse, 120, and a temperature of 101°. Per vaginam the uterus was felt, and what seemed to be the left ovary and tube adherent to posterior surface which was much enlarged and exquisitely sensitive. On account of patient's grave condition and its evident pelvic origin, a further examination was not made, and abdominal section advised. This was done on May 14th, and the following condition of things was found: Peritoneum was so thick that it seemed more like a cyst wall than what we usually find, and adherent to its upper surface were coils of small bowel. A large quantity of foul fluid, serous and purulent, greasy in part, was found, and floating in it were several strains of hair; it flowed out of the peritoneal opening and from loose adhesions to bowel, uterus, pelvic tissues. The longer (right) tumour was enucleated, it had evidently burst, and from the vent there protruded a coil of hair quite 4 ins. in length. The pedicle had become twisted once round. This was secured in the usual way, and the tumour, as large as a foetal head at term, removed.

Deep down in Douglas' pouch, surrounded by adhesions, was found the left ovary—also a dermoid—brought to the surface, and removed. This tumour was of the size of a Tangerine orange.

The cavity was drained for 24 hours, and the patient made an uneventful recovery.

Transactions of Societies.

BRITISH GYNÆCOLOGICAL SOCIETY.

MEETING HELD THURSDAY, JUNE 14TH, 1900.

The President, W. J. SMYLY, M.D., in the Chair.

SPECIMENS.

DR. W. H. A. NEWNHAM (Bristol) showed a specimen of uterine myoma removed by supra-vaginal hysterectomy, which will be found under "Clinical Records."

DR. C. H. F. ROUTH asked whether there was any

(a) Specimens shown at meeting of the British Gynæcological Society, June 14th, 1900.

cause for the production of this tumour? He realised more and more that these fibroid tumours arose from too much life in the uterus, when it did not receive the relief, in the form of pregnancy, which it ought to receive. Was any such cause at work in this case?

Dr. NEWNHAM replied that he did not know of any cause for the tumour in this case.

Dr. G. ELDER (Nottingham) showed two ovarian dermoid tumours removed from the same patient. The notes will be found under the head of 'Clinical Records.'

Mr. J. FURNEAUX JORDAN (Birmingham) showed a series of specimens removed by vaginal coeliotomy.

THE INDICATIONS FOR THE REMOVAL OF THE UTERINE APPENDAGES.

The discussion of Dr. Macpherson Lawrie's paper (MEDICAL PRESS AND CIRCULAR, May 30th,) on this subject, which was adjourned from the May meeting, was opened by the following communication from Dr. MACNAUGHTON-JONES (who was unable to be present), to the author:—"I regret much that I am prevented from taking part in the discussion on the important subject dealt with in your paper. With regard to your conclusions as to the grounds that justify removal of the adnexa, I may say that I am generally in accord with them. I suppose that the teaching of modern gynaecology is practically unanimous in the instance of any extensive pelvic suppuration involving the ovary and tube of one or both sides; (a) in cases of disease of the oviduct, suppurative, cystic, or other, destroying its integrity and obliterating its lumen; (b) in blood cysts, both of the ovaries and Fallopian tubes; (c) in certain solid tumours of the ovary, both malignant and non-malignant; and (d) in the majority of cases of ectopic gestation. On the borderland of such conditions there will ever be a pathological area, in which we can only determine the course to pursue by the individual nature of, and the complications associated with, the diseased condition we find within it. Nor, indeed, is it desirable that by any hard and fast survey of what must be, until explored in each particular case, a *terra incognita*, we should attempt the impossible, and by any general rule hamper or restrict procedures which are best left to the discretion of the operator at the time. Debateable questions are those raised by you on the extent to which conservative surgery of the adnexa may be pushed with safety to the woman, the influence of salpingo-oophorectomy on bleeding fibro-myoma, and the justification for the operation for various subjective symptoms, and in a certain class of patient in whom a train of nervous phenomena, physical or mental, is associated with affections of the adnexa. This opens a large question, each section of which would demand careful and unbiased consideration. I think in the case of fibro-myoma you have put the position fairly, though in view of what may be done by enucleation, either by coeliotomy or colpotomy, with or without resection of the ovaries, we are still further limiting the number of cases in which removal of the adnexa will be practised for bleeding or growing myomata. As to that very large number of sufferers from reflex troubles and nervous conditions, in whom we find or do not find gross changes in the genitalia, it has to be remembered that it has often been demonstrated and proved that the pathological changes found in the ovaries and tubes, though not apparently of great importance on examination beforehand, have been of a most grave character, incurable in their nature, and therefore wrong to leave unremoved. While, therefore, depreciating the removal of adnexa, in which incurable degenerations have not occurred, and where conservative surgery might be expected to place the woman in a safe condition for her future life, we must recollect the frequency with which secondary degenerations occur, and the utter uselessness for procreative purposes of the majority of such adnexa. I take it that your contention is in accord with that of nearly all gynaecological teaching, that on the general question of removal of the entire or part of the internal genitalia, such removal is not to be considered save, first, where other therapeutical steps have either been

tried and proved valueless, or the procrastination involved in resorting to them is both directly and indirectly dangerous to the woman, and also where the risk run in operation is less than that to be taken by non-interference. As to the often fought out question as to route, seeing that it is clear that some cases may be most readily dealt with, and certainly with less risk, by colpotomy, and others, even if the operative risk be slightly increased, by coeliotomy, here again I think it is vain to endeavour to formulate conditions which cannot be universally applicable. Those which are to be dealt with by either route have fairly clear indications in their nature and complications sufficient to guide or influence the selection of the route. Surgery is advancing not on the lines of definitions and limitations, whether pathological or operative, and certainly experience generally does not tend to show that in the face of radically altered structures, incomplete, quasi-curative, and expectant procedures, are, in their ultimate issues, satisfactory."

Dr. C. H. F. ROUTH said that he strongly opposed heroic surgery of the uterine appendages. It would be within the recollection of the Fellows of the Society that he read a paper on the subject summarising not only his own views but also the opinions of all leading authorities. That paper was read at a time when the tendency to operate was very great, but since then the tendency had fallen to a great extent. Dr. Macpherson Lawrie's paper was a going back on the question. For himself he took exception to some of Dr. Lawrie's conclusions. Thus with regard to the cases summed up in the paper as Group "A," he denied that inflammation of the appendages was any ground for their removal, any more than would be the case with the liver. He had had many of these cases, and except in one instance he had never agreed to removal. In the instance in question the tumour ruptured during extraction, pus escaped, and the patient died. If a patient had a tumour in the neck, he would not at once proceed to remove it, but would apply leeches, blisters, &c., and the tumour would probably get smaller. Why should they not apply the same principles to the treatment of the diseases of women? His own plan was to first aspirate the tumour, and then inject iodine. They had no right to injure a woman for the sake of an operation. Again, if a woman had pain in the ovaries, they had no right to remove the ovaries any more than they had a right to remove a man's testicles on account of pain, they should apply leeches or blisters, divide the uterus and bleed it, do curetting, &c. Removal of the ovaries altered the frame of the woman's mind, and tended to insanity. They should also remember that many of the symptoms presented by these patients might occur without any lesion being present. Dr. Kingston Fowler collected notes of 841 autopsies, and of that number only 15 cases had disease of the ovaries. The difficulty of diagnosis was another reason for not operating; for there were many cases that might seem to be suitable for operation, and that might nevertheless be cured by milder measures.

Dr. G. ELDER (Nottingham) thought that the Fellows of the Society ought to feel greatly indebted to Dr. Macpherson Lawrie for bringing such an important paper before them. None of them doubted the propriety of extirpating the appendages for pyosalpinx, suppurating ovaries, extra-uterine gestation and tumours, and some of them believed in removing the ovaries for myoma in certain cases; he had himself had several such. But with regard to Dr. Lawrie's group "A," there were grounds for discussion. When the late Lawson Tait had the inspiration to remove the ovaries and tubes in the case of inflammatory conditions, it was a great advance on previous methods; no doubt many ovaries and tubes were subsequently removed that ought to have been allowed to remain; probably most of these present had removed ovaries which on after-consideration they would have left inside. This was formerly—and as for himself, what made him reconsider the matter was the fact that in some instances after the removal of the appendages the pain was no better than before, and the patient had been exposed to a serious operation for no good. In many cases it was very difficult to know what to do; the

patient, perhaps, went on from month to month without improvement, and it was perhaps difficult to desist from operation. His own practice now in doubtful cases was always to examine the patient under an anæsthetic, and, if necessary, to make an exploratory incision. If the ovaries appeared to be healthy he left them; in other cases he resected any unhealthy portions. Certainly the general rule of operators was now to leave as much as possible.

Mr. STANMORE BISHOP (Manchester) said that while he would wish to be acquitted of any desire to impede the progress of surgery, there were yet some statements in the paper that were open to debate. Thus Dr. Lawrie said "What these patients require above all is not the preservation of this or that organ, but relief from their suffering; this much they have a right to demand, and this much it is our duty to grant them." This statement, it seemed to him, went too far, or not far enough. Patients also had a right to demand that they should not be transferred from the frying-pan into the fire. Inflammation of a Fallopian tube was not a valid ground for its removal. He also took exception to Dr. Lawrie's recommendation that a pyosalpinx should be tapped and drained. Did the author insure that he would evacuate the pyosalpinx by means of a trocar? If so, it would fill up again. A free incision was alone efficacious. Dr. Lawrie gave two classes of cases of myoma where he advocated oophorectomy: first, when the myoma was small and the appendages were diseased; and secondly, when the patient was weakened by hæmorrhage. In the first case, he presumed that Dr. Lawrie removed the appendages because they were diseased, and not on account of the presence of the myoma. In the second case, he would point out that in many instances the removal of the ovaries was not enough to control the hæmorrhage. And as to the statement that a second operation for the removal of the uterus could be performed, his own view was that a second operation was always bad for the patient.

Mr. FURNEAUX JORDAN (Birmingham) agreed with the greater part of the paper. Dr. Elder had, he thought, put the matter in a nut-shell when he said that the discussion would turn mainly on the justifiability of removing the appendages in Class "A." Dr. Lawrie thought that the conservative reaction had gone too far; for his own part, he did not believe that this was possible. As long as the operation was aseptic, any conservative procedure could be safely done. In one case of pyosalpinx he incised and washed out the tubes with a good result; in another case of cystic ovaries he removed one ovary, and dealt with the other by ignipuncture, and this patient bore a healthy, living child twelve months later. They must recognise, however, that the advocates of removal of the appendages for inflammation did not urge this treatment for every case, but only when the conditions were such as to endanger the life of the patient; and every such case must be judged individually. When pain was the chief symptom complained of, the patient was often well nourished, and in such cases, especially if the appendages were not enlarged, no operation should be done. He would go further and say that in no case should appendages be removed unless they were palpably diseased. For the determination of this point an exploratory incision was often valuable. With regard to oophorectomy for myoma. Dr. Lawrie had accurately expressed his own views; if the patient was much blanched and enfeebled, hysterectomy might be too severe, for even if it were granted that the mortality of hysterectomy was not greater than that of oophorectomy, there was no doubt that the former was a longer operation. If a second operation were needed, the patient meanwhile attained a better condition for going through it, for even if hæmorrhage recurred after oophorectomy, it seldom recurred until after several months, and he could testify that under these circumstances hysterectomy was really an easier operation, for he had done it three times after a previous oophorectomy.

Mr. BLAND SUTTON made a contribution to the discussion, which will be found in full on page 647.

Mr. F. BOWREMAN JESSITT, after thanking Dr. Lawrie for his important paper, said that he thought that Dr.

Lawrie's attitude had not been well understood. It had been assumed that he advocated operation in all cases; whereas he specified that it should be restricted to cases of incapacity where other methods had failed; and for his own part he agreed with Dr. Lawrie that if the operation restored the patient to health, it was justifiable. It was true that there were cases in which no improvement resulted. Dr. Mary Dixon Jones had shown that there were cases in which the ovaries presented no enlargement and yet were much diseased; and he imagined that some of Dr. Lawrie's cases came under this category. With regard to pyosalpinx, it seemed to him that to tap and inject iodine would be much more risky than to remove the tubes through the abdomen. Among other risks, the sac might contract after evacuation, with the result that the iodine was injected into the peritoneal cavity. He agreed with Mr. Furneaux Jordan's views as to the indications for removing the ovaries in cases of myoma.

Dr. ROUTH remarked that he had used his plan of injecting iodine in many cases and had never lost a patient.

Mr. SKENE KEITH said that he was a conservative surgeon, and often relied on conservative methods, such as electricity, which some of his fellow-surgeons appeared to taboo. He did not believe in removing ovaries from a patient in perfect health. There was a condition of ovaries to which no reference had been made, in which the ovary appeared healthy on the surface, but on cutting it open there was a thick capsule almost as hard as cartilage. With each recurrence of ovulation much pain must necessarily result, and the patient become emaciated. If the general health of a patient was not thus affected, it was not time to operate. He would be afraid to adopt Dr. Routh's plan; but he had had good results from painting with iodine. He did not think that insanity was common after oophorectomy; but he had not infrequently known the operation to be followed by changes of temper. He did not agree with Mr. Bland Sutton as to oophorectomy for myoma; if the whole of the ovaries were removed, he would guarantee cure of the hæmorrhage.

Dr. FRED EDGE thanked Dr. Macpherson Lawrie for his valuable paper. As regards the cases grouped under "A" there could never be, from the nature of things, any certainty; and difficulty must always exist as to how bad the patient really was, how far the general medical treatment had been carried out, and to what extent the patient's usually limited mental conception had grasped the nature of the operation. It was also to be remembered that the after-condition was not always perfect. He did not refer to the effects of removal of the ovaries and tubes, but to the pains and aches and trouble following in the wake of any surgical operation, and was too much taken for granted that removal of the appendages would give relief to their sufferings and restoration to a condition of health and usefulness. And when it was said that "this much they had a right to demand of us, and this we must give them," they were using a very fine phrase meaning nothing more or less than that they were minor deities, and taking for granted their power to restore the patient to health and usefulness, which was sometimes doubtful even to themselves. Each case must be decided on its own merits, and the patient made fully conscious of affairs. *Conservative operations.*—No doubt the results of conservative operations on the appendages had been disappointing in many cases, but they have been equally gratifying in other cases, and the practical point was to find out in which cases it was well to use conservative methods. It had struck him that the cases where conservative operation failed were much the same as those in which the removal of the appendages was not followed by clear and full recovery, that is, the uterus and other pelvic structures were implicated, and either radical removal of uterus and adnexa should be performed or the case left to medical treatment. In cases of enlarged cystic ovaries with no adhesions it was not necessary to remove the whole ovary, and the solid, fleshy portion might be left. It was a rule with him to remove appendages and not try conservative operation in gonorrhœal cases, but Mr. Taylor had shown that many

of these cases had a syphilitic basis, or at least alternative treatment would relieve them. If all women suffering from the group of symptoms given as indicating removal of the uterine appendages were to be so treated they would want much larger hospitals. And this brought him to the mentioning of the curious manner in which one's operations alter with fashion and the want of beds; it seemed as if hysterectomy and vaginal conservative operations had taken the place of many operations for removal of the appendages merely by taking up the beds. The only cases of myoma in which he removed the appendages were the ensanguined, so ably pointed out by Mr. Jordan; the cases of disease of the appendages, and a third group where the myoma involved the whole uterus and was displaceable from the pelvis and the appendages could be removed with great facility and safety. Whenever the appendages were adherent in cases of myoma, it was generally a mistake to remove them, because some portions of ovarian tissue were generally left behind, and the aim of the operation was thus missed since menstruation continued.

Mr. CHARLES BYALL said that the tendency to remove the ovaries had been diminished since it was realised that they had a function of internal secretion which had an effect on the whole system. It was to be remembered that simple cystic disease of the ovary was not a very grave condition, and could be dealt with by conservative methods such as puncture, excision of a wedge of tissue, &c. He believed that oophorectomy for myoma should be dropped except in the conditions mentioned by Mr. Furneaux Jordan.

Dr. ARTHUR GILES said that the justifiability of operations of the class grouped together by Dr. Lawrie as Class "A" must largely depend on their results. If a condition incapacitated a woman, and prevented her from earning her living, and an operation would restore her, he thought that Dr. Lawrie was right in saying that the patient had a right to demand relief, and that it was the duty of the surgeon to endeavour to give it her. It had been truly said that some of these operations failed; an important factor, which introduced uncertainty into the results of all kinds of operations, was the neurotic temperament. Many of the patients in Class "A" were no doubt neurotic; and it was well to remember this, since any operation on such a patient was likely to be a failure as regards general symptoms, even if it cured a given local condition. He strongly discountenanced any operation on such patients, except those that were urgently necessary. He pointed out that oophorectomy had failed to relieve hæmorrhage in cases of myoma, not only owing to a portion of ovary being left behind, but also because the operation had been done in cases where the bleeding was due to a myoma that had become polypoid. In any case where oophorectomy was contemplated, he thought that the cavity of the uterus ought to be first explored, to eliminate this source of failure. The cases of myoma requiring oophorectomy were now, in his opinion, very few.

Dr. MACPHERSON LAWRIE, in reply, said that he thought this was probably not the last discussion that they would have on this subject, for it was a burning question. Part of his paper was on questions generally accepted; but on other portions there was evidently still great divergence of opinion. Some of the speakers appeared to assume that he advocated operation in every case of salpingitis; this was not the case, it was only in the case of the residue of intractable cases that he advised operation. There were cases that resisted all medical treatment and all milder measures; something had to be done to relieve them; and if an operation would accomplish this he held that it was justified. He had listened with interest to Dr. Routh's remarks; but he could not go so far as Dr. Routh. Dr. Routh had spoken of cases in which he had tried palliative treatment, and they had recovered. In this there was nothing unusual; they had all had such cases. But the question was: What were they to do with the cases that did not recover? He gathered from Mr. Bland-Sutton that the cases of tubal disease which required removal were cases of

inflammation and of ectopic gestation; and this was precisely the view that he had himself advocated.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

SECTION OF MEDICINE.

MEETING HELD FRIDAY, MAY 18TH, 1900.

The President, Sir J. W. MOORE, M.D., in the Chair.

CASES OF CEREBRO-SPINAL MENINGITIS.

Dr. H. C. DRURY read a paper on "Cases of Epidemic Cerebro-Spinal Meningitis," and related eight cases which he had met with in Cork Street Fever Hospital. The first, a man, æt. 20, was admitted on November 18th, 1899, and after a prolonged illness recovered. The second, æt. 12, also recovered after a very protracted illness. The third case, a man, æt. 48, died on the fourteenth day. The fourth, a man, æt. 21, was a very chronic case, and recovered. The fifth, a man, æt. 19½, died on the sixth day, with very acute symptoms throughout. The sixth was a girl, æt. 17, who died on the tenth day. This was a somewhat doubtful case, as there was double otorrhœa, and lumbar puncture failed to withdraw fluid; but the symptoms were less those of cerebral abscess or meningitis from middle ear disease, than of epidemic meningitis. The seventh case was a female child, æt. 6, who died on the fifth day. The eighth, a male child, æt. 7, still alive on the eighteenth day, but with severe symptoms. Of the eight cases four died. In only one was there a rash—a feature so typical of the great Dublin epidemic of 1866-67—and this rash was not petechial, but pustular, with hæmorrhage into the pustules, and it came late in the disease. All the cases commenced suddenly, had rigidity of neck, or actual retraction of the head, with, in some cases, opisthotonos; all had deafness in some degree, pain in head and limbs, and Kernig's sign. One case was mentioned though not included in the above eight cases, which, without bacteriological examination, could not have been diagnosed. That was a man, æt. 50, who had had pneumonia, and was up about the ward convalescent for a week, when he suddenly developed most marked symptoms of acute meningitis, and died on the fourth day. A post-mortem revealed pus all over the meninges, and a fungous growth on one of the aortic valves. This vegetation and the pus yielded pure cultures of pneumococcus and not the diplococcus intracellularis.

Dr. FALKNER presented a table, showing the number of deaths in the Dublin Registration Area from all forms of meningitis in the years 1895-1899. Taking the years 1895 to 1899 inclusive, the average number of deaths from all forms of meningitis, for the first 19 weeks in each year, was 102·6; but in 1900 the number of deaths in a corresponding period was 182·0, and the increase embraced ordinary meningitis, tuberculous meningitis, cerebro-spinal meningitis, hydrocephalus, and secondary meningitis. All forms of meningitis should be treated as zymotic diseases. He thought Sir Charles Cameron had adopted the proper course in making meningitis a notifiable disease.

The PRESIDENT remarked that that was the first occasion in which meningitis had been made a notifiable disease. He thought Sir Charles Cameron's advice very judicious—namely, to require notification for only four months. He was struck with the coincidence of the outbreak and the arrival in Dublin of the 21st Lancers from Omdurman, where the disease had appeared in severe form lately. However, on inquiry, he found that no case of cerebro-spinal meningitis had occurred in the regiment before or since its arrival in Dublin. At the Meath Hospital they had had 11 cases, with three deaths, and eight cases still under treatment. This showed that the mortality was not at all so high as in the epidemic of 1867. The first case was a girl, æt. 3, admitted on February 24th; she recovered. The second case was a girl, æt. 16, who came in insensible, and died quite suddenly within twenty-four hours of admission. In the third case, which also proved fatal, there were evidences of lepto-meningitis. The appearances brought

he turbid fluid and in the pus, usually in pure culture. It grew best on Löffler's serum, but also on glycerine agar, and less actively on ordinary agar.

Professor McWENNEY said that the first case which had come under his notice was that of a schoolgirl, who was thought to have tuberculous meningitis, and who died in the Mater Misericordiae Hospital early in February. He was much struck by the presence of an accumulation of thick mucoid pus symmetrically placed in the posterior cornu of each lateral ventricle. Microscopic examination of the material at once revealed the intracellular diplococcus which he had never previously seen. In all the cases he had subsequently examined post-mortem the same features recurred; occurrence of actual suppuration, the pus being very tough and mucoid; symmetrical disposition of the lesions on each side of the brain; distension of the lateral ventricles with turbid fluid; implication of the sides and back of the cord; and paucity of the intracellular cocci in the fibrinous exudation on the membranes. He had always found them more abundantly in the sediment obtained by centrifuging the ventricular fluid. The resemblance to the gonococcus in various respects was very striking. A noteworthy point was the possibility of finding the meningococcus in the nasal mucus. In the very first case he attempted this, the intracellular cocci was at once found. In epidemics of cerebro-spinal meningitis the use of antiseptic nasal douches, and the disinfection of the nasal secretion and sputum, seemed to him important measures. There was a disease of horses, known in Germany as Born's disease, in which the essential lesion was a cerebro-spinal meningitis. Intracellular cocci had been found in the pus, and it seemed quite possible that the disease might prove to be identical with human cerebro-spinal meningitis. He had heard that numerous cases had lately been observed in horses about Dublin, and this was of interest in connection with the present epidemic among human beings. The Section then adjourned.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

MEETING HELD WEDNESDAY, JUNE 6TH, 1900.

Mr. A. G. MILLER, President, in the Chair.

DR. JAMES CAMERON showed a case of "Adiposa Dolorosa," which had undergone some improvement under thyroid treatment. There were no mental symptoms.

Mr. C. W. CATHCART showed (1) a patient after laparotomy for intestinal obstruction of three days' duration from adhesions due to calcareous tuberculous glands. (2) A patient, æt. 72, after excision of gangrenous bowel after strangulated hernia.

Mr. CATHCART showed a surgical operating case of new design; also portion of sigmoid flexure removed for malignant growth.

Dr. LEWIS C. BRUCE read a paper on

THE GENERAL BLOOD PRESSURE IN SLEEPLESSNESS AND SLEEP.

The observations were made on patients in Murthly Asylum, and the instrument used for estimating the blood pressure was Barnard and Hill's sphygmometer. The normal blood pressure in the recumbent position was taken to equal 110 millimetres of mercury. The first question which arose was whether there were unusual changes in the blood pressure in cases of sleeplessness. Sixteen cases were examined, and it was found that in twelve the blood pressure was from 130 to 150 mm. Hg., while in four it was from 100 to 110 mm. Hg. The cases thus fell into two groups, one with high and one with low blood pressure.

In the first group paraldehyde in doses of two drachms always acted well; in a quarter of an hour the patients were asleep, and the blood pressure had fallen to normal. In the second group the same doses of paraldehyde failed to give sleep; the patients became restless, and the blood pressure rose to 130 or 150 mm. Hg. If, however, small doses—15 minims—of paraldehyde were given a satisfactory result was obtained. Trional and sul-

phonal were also tried: the two drugs seemed to have a very similar effect, but trional acted more quickly. These drugs did not act so well in cases where the blood pressure was high; they were uncertain, but when sleep was procured, the blood pressure fell. In cases with low blood pressure, on the other hand, they were invariably successful, the pressure remaining at the same level, or even falling a little. Some observations were made on bromides, but without any very definite results. From these observations the general conclusion was that in insomnia with high blood pressure (the commonest type) paraldehyde in full doses was indicated; in cases where the blood pressure was low small doses of paraldehyde, or, better, sulphonal or trional should be used.

In nine cases of insomnia with high blood pressure a simple depressant—erythrol tetranitrate—was tried. It was given in doses of half a grain night and morning, increasing to double that amount. In three cases there was unqualified success, in three a partial cure, and in three no benefit was obtained. He found that if erythrol tetranitrate was going to act well it acted at once. In cases of mental overfatigue increased blood pressure and sleeplessness were the first signs of impending breakdown, and this might be prevented and sleep secured by the use of erythrol tetranitrate. Observations were made upon 30 convalescent patients in order to discover (1) whether sleep was possible with high blood pressure; (2) the relation of the morning blood pressure to that of the evening; the difference between the blood pressure in paraldehyde sleep and natural sleep. It was found that only two of the 30 cases showed high blood pressure, and even in these, as sleep occurred, the blood pressure fell. As a rule the morning blood pressure was higher than that of the evening; a high evening pressure was often the precursor of an attack of insomnia. When a patient fell asleep as the result of a dose of paraldehyde the blood pressure fell considerably; after the effect of the drug passed off and the patient fell into a natural sleep the pressure rose, though never, of course, as high as in the waking condition. The difference between the blood pressure in paraldehyde sleep and natural sleep was about 10 mm. Hg.

The paper was discussed by Drs. Clouston, Foulis, Kerr, and Ronaldson, and Dr. Bruce replied.

Dr. Foulis read a paper on

THE ORIGIN, STRUCTURE, AND DEVELOPMENT OF THE UMBILICAL CORD.

The gist of his contention was that the cord had no covering of amnion at any period, but was entirely within the sac of the amnion, and was a tubular prolongation of the somatopleura round the collapsed and shrivelled yolk sac. As the amnion became gradually distended with fluid it was lifted off the embryo at all parts except where it was attached to the "Bauchstiel" and to the somatic folds round the umbilical foramen, which were now closing in round the shrunken yolk sac. As the somatic mesoblast surfaces of the splanchnopleura came in contact round the yolk sac they shut off the body cavity from the amnion. By this closing and adhesion of the opposing surfaces of the somatic mesoblast a tube was formed round the yolk sac. The amnion did not cover this tube—the future umbilical cord—but was continuous with it at its distal end. The amnion could be stripped off the placenta, but not off the cord, of which it was an extension and a part, not merely a covering. The paper was illustrated by a number of lantern slides of sections of early deer and sheep embryos. Dr. Berry Hart discussed Dr. Foulis's views, and Dr. Foulis replied.

On account of the lateness of the hour a paper by Mr. A. G. Miller on "Residual Urine in Cases of Enlarged Prostate," was postponed.

The governors and medical staff of Guy's Hospital have originated a Garden Party, to be held on Wednesday, the 4th prox, on the occasion of the distribution of medals and prizes by the Earl of Pembroke. University graduates are requested to attend in academical costume.

The Paris Exhibition.

[BY OUR SPECIAL COMMISSIONER.]

II.—SOME SURGICAL APPLIANCES.

Sterilisation and Asepsis.—It is very noticeable what a large part sterilisation plays in the various departments of medicine, surgery, and hygiene. A great number of appliances for sterilising instruments and bandages are shown, notably that of Leclerc—who also has a most complete display of instruments, bandages, silks, &c., sterilised and packed in bottles ready for sending away; also special surgical cases containing instruments, needles, bandages, silk threads, sponges, &c., all sealed in bottles and put up for surgeons operating at home. There are several large houses which make a speciality of sending out sterilised materials for operations, as well as complete cases with instruments, sounds, &c. Besides this there are two or three ingenious sterilising appliances for use in small hospitals and military camps. Dr. F. Gendron's specimens are remarkable. He shows sponges of varying degrees of fineness, packed in hermetically sealed glass jars. These sponges are sterilised by a careful treatment with chlorohydric acid, permanganate of potash, and hydrosulphite of soda. Packed in tin boxes are "compress sponges," composed of absorbent gauze, which have been simply sterilised in the autoclave, without addition of any antiseptic agent. Packed in the same way are large sterilised gauze serviettes. Cat-gut (previously freed from grease, and sterilised in anhydrous alcohol under pressure of four atmospheres), is wound round a glass rod, placed in a glass tube, which is sealed with a broad band of india-rubber and a gummed label. Silk and Florentine horsehair are put up in the same way, though the sterilising is done by means of steam. Sounds, drainage tubes, &c., are all sterilised and put up in glass tubes or metal boxes. Indeed, precautions to ensure perfect asepsis are noticeable in every direction. Glass, enamelled metal (preferably in the form of tubes), and aluminium are chiefly used in the construction of hospital fittings. A good example of this is to be seen in the diphtheritic isolation cubicle adopted at l'Hôpital des Enfants Malades, and shown by the Assistance Publique. The partitions are of glass in metal frames, and every item of the furniture and appliances is of crystal or metal with a glass-like enamel.

Operating Rooms and Operating Tables.—Another excellent object-lesson is afforded by the model operating room fitted up by Flicoteaux, Barne et Boutet, of 83, Rue du Bac, Paris. The partitions are partly of glass in metal frames, and partly of opal glazed tiles. All the fittings are of glass, nickel or enamelled pottery. The little room is crowded with interesting appliances, including a folding table with hinged and adjustable platform, capable of being utilised as an inclined-plane table for operations; a clever apparatus for injections, consisting of adjustable glass barrels supported in a metal frame on castors, and fitted with indiarubber tubes, &c., and a good pattern of spittoon in glass. This spittoon is shaped somewhat after the fashion of an old well ink-bottle, but a "kick" or pyramidal lump of glass almost closes the opening, so that evaporation and escape of dried particles is impossible, and a capsize can do no harm. For cleaning purposes the top guard can be removed. Among the sterilising appliances shown by this firm is a small stove for passing instruments through steam, and heated by gas or alcoholic flames; also an electrically-heated instrument steriliser.

One of the successes of this section is Dr. Richelot's folding surgical table. It is a beautiful appliance, manufactured of steel tubes covered with a vitrified glaze. The supports consist of four feet arranged in the form of a double X, which ensures perfect stability. The table itself is made in two pieces, to enable the body-part being inclined at angles sufficient for ordinary operations, or those connected with the vagina or abdominal surgery. The steel tubes of the body part of the table are covered with a thin sheet of aluminium. In this way Dr. Richelot (so well-known in connection

on the water supply, for there is a widespread suspicion that other sources of contamination exist, notably in respect of vegetables grown on the various sewage farms around the metropolis. In a country where salads and uncooked vegetables are consumed on such a large scale the risk of contamination from this source is necessarily much more marked than where only cooked vegetables are eaten. The worst of it is that under existing circumstances Paris is likely to prove a focus of infection which will spread far and wide, especially as the incubation period of typhoid is of considerable duration.

THE METROPOLITAN ASYLUMS BOARD AT THE PARIS EXHIBITION.

Great interest attaches to the exhibits of the Metropolitan Asylums Board at the Paris Exhibition. In the section of Social Science a number of models and charts are exhibited in illustration of the Board's work, as the administration which controls the transport accommodation and treatment of the infectious sick, and provides for the reception of certain classes of the insane. The work of the Board is dealt with at considerable length in the current number of *La Semaine Médicale*, based on the report which the Board has had translated into French for the benefit of non-English speaking visitors who may be interested in learning how this admirably-managed organisation does its work.

THE USE OF RUBBER GLOVES IN SURGERY AND OBSTETRICS.

This vexed question is the subject of an interesting article in *La Semaine Médicale* by Dr. E. Wormser, who discusses the pros and cons, and arrives at the conclusion that the balance of convenience is in favour of their use. He points out that the hands, being less exposed to the deteriorating influence of moisture and caustic antiseptics, the skin is less apt to chap, and consequently less apt to prove the vehicle of infection. In tying ligatures again there is less risk of lacerating the skin, thus avoiding a well-recognised danger to the surgeon or obstetrician, and, lastly, after an operation the gloves are much easier to sterilise than the more absorbent skin of the hands.

THE DISTRIBUTION OF GOITRE.

Dr. Poncet, of Lyons, recently communicated to the Academy of Medicine the results of researches made on the present distribution of goitre in France. He estimates the number of goitrous persons roughly as between 375,000 and 400,000. These are not by any means evenly distributed all over the country, on the contrary a small group of departments are responsible for an unduly large proportion, notably those bordering on the Alps, the Pyrenees, the Jura, the Vosges, and, lastly, the central plateau. The departments of the Aisne and the Ome alone show up as black spots in otherwise unaffected districts. He states that the number of goitrous persons has notably diminished especially during the last fifty years, but the distribution has not undergone any marked change.

THE first stone of the new infirmary at Newcastle-on-Tyne was laid by H.R.H. the Prince of Wales on Wednesday last, and the occasion was made a public holiday.

Germany.

[FROM OUR OWN CORRESPONDENT.]

BERLIN, June 23rd, 1900.

At the meeting of the Medical Society, Hr. Dürrsen showed a specimen of

CARCINOMA OF THE PORTIO,

which showed how rapidly the disease could sometimes advance. The patient, a woman, *æt.* 38, was three weeks previously quite healthy. On March 7th she had hæmorrhage lasting four days, which returned after a free interval of ten days. In this short interval the posterior lip of the cervix had become converted into a cancerous nodule the size of a hen's egg. The practical interest of the case lay in the importance of hæmorrhage as a symptom, and it showed how necessary a local examination was in all cases of hæmorrhage, even in younger women. It further showed that the first symptom of cancerous disease in women was not pain as generally believed, but a change in the uterine discharges. Perhaps more would be done in lessening the mortality of cancer in the way of early diagnosis than in the finding of an undiscovered bacillus. Without a disposition to inflammations, as remarked by Virchow, carcinomata would hardly develop, even if a bacillus should play a part in the disease.

At the Surgical Congress, Hr. Kehr, Halberstadt, showed a patient on whom

GASTRO-ENTEROSTOMY

had been performed three times. The patient was an elderly woman who suffered from ileus. The first operation was a Hacker's with Murphy's button. The success was not lasting, as in six months vomiting returned, which was not relieved by washing out the stomach. Laparotomy was again performed, and the posterior gastro-enterostomy was found very much contracted. Wollfler's anastomosis was now done with a large opening and serous sutures. The course was favourable, but in six months the symptoms again returned, so that operation was decided on for the third time. The afferent loop of intestine was dilated, the efferent contracted, the opening being contracted by a spur. The loop was resected. The result was excellent. The speaker considered that the Murphy button did not leave a sufficiently wide opening; he preferred sutures.

Hr. Kehr then related a

CASE OF GASTRO-ENTEROSTOMY IN A CHILD OF SIX MONTHS FOR STRICTURE OF THE PYLORUS.

He showed the child that had been then operated on six months before. The infant had developed normally during the first few months of its life, then it began to vomit every time it took food and to emaciate, losing weight from 4½ to 3 kgrms. He diagnosed stenosis of the pylorus, and this was confirmed when the operation was performed. Wollfler's operation was the one selected. No collapse appeared during the operation, and two hours after its completion the child was put to the breast and it soon picked up. A second case was that of the child of a colleague. The diagnosis was made by the infant's father. For four weeks the child did well, and then vomiting set in, which gradually got worse, until it followed always after partaking of food. The weight fell from 4 to 2½ kgrms. When nine weeks' old the child was admitted into the klinik. A tumour could be felt in the epigastrium. Hacker's operation

was the one performed. There was some fever afterwards, but it subsided in 36 hours, and complete recovery took place. Stenosis in infancy was probably more frequent than had been imagined; only a few cases were recorded. An important symptom was the long delayed stool. No food passed into the bowel, so no fæces were formed. For keeping up the strength he had injected 100 grms. of saline solution every three hours.

Hr. Lindner, Berlin, was a warm partisan of the Wollfler operation; it was uncommonly safe, very simple, and peritonitis never followed, nor had he ever seen ileus after it. The unnatural arrangement of the bowel arose from the idea of the person spending a good part of his life in the erect posture, and that this arrangement provided for an outflow. After observation of such operations for years, he had never seen any deviation from the normal even in extensive cancer of the pylorus; such patients did not die from defæcation troubles, but from general cachexia, spread of the disease to the liver, &c. Manual dexterity was of greater importance than any new method of operating, but the addition of an entero-anastomosis would be an improvement. During the past few months he had performed 22 gastro-enterostomies with only two deaths.

Hr. Kronlein had gradually inclined to suture in place of instruments, and his results had steadily got better. The operation itself was perhaps easier with the button or forceps, but safety only lay in a good suture. Saving of time was of importance, particularly in cases that had got very low; but safety was still the chief thing. He had at one time performed the Wollfler operation, but later on he began with the Hacker, and still stuck to it. He had done a total of 55 gastro-enterostomies and 40 resections of the stomach for carcinoma.

In connection with the

TREATMENT OF BENIGN STRICTURE OF THE PYLORUS, Hr. v. Eiselsberg reported the following cases:—A lady, *æt.* 30, had suffered for years from gastric troubles and hæmatemesis. He operated, and found on the lesser curvature a chronic ulcer. This was excised, and the patient made a good recovery. 2. A lady with hæmatemesis. On laparotomy being performed, an ulcer was found at the pyloric inlet, with contracture of it. Gastro-enterostomy was performed, but the bleeding returned; and a second laparotomy was rendered necessary, when a second ulcer was found near the cardiac end. A third case was one of carcinoma of the cardiac and of the pylorus in a woman, *æt.* 60. He had operated in six cases of stenosis of the pylorus from caustics. He preferred posterior gastro-enterostomy.

Austria.

[FROM OUR OWN CORRESPONDENT.]

VIENNA, June 23rd, 1900.

STRUMA, GANGRENE, &c.

At the last meeting of the "Gesellschaft der Aerzte," Weinlechner showed a few cases under his care in hospital. The first was a boy with a sort of hood over the penis, leading to extensive œdema and pain. He incised the foreskin and was using pressure. The second was a boy, *æt.* 15, on whom he had operated for struma by tying both the superior thyroid arteries. Within three weeks the gland had markedly decreased.

town. In every million of the population there have been 112 suicides of Germans, 47 of Slavs, and 105 of French. In the summer season 60 occurred, and in the winter 40. Taking each month January had 9, February 10, March 10, April 7, May 15, June 15, July 14, August 12, September 11, October 8, November 12, December 18. The days of the week were Monday 24, Tuesday 31, Wednesday 25, Thursday 38, Friday 17, and Sunday 32. Sundays and holidays are specially allocated for females. The ages in males average 25 to 35 years of age, while females are from 15 to 20 years. The oldest male was 76, the oldest female 75 years. Out of 209, 153 were males and 56 females; 80 were single, while only 30 were married, and four were widows. The methods of the suicides were—81 by shooting, 70 by poison, 16 drowning, 24 hanging, and seven by placing themselves before trains; 140 were civilians and 69 belonged to the army.

In comparing periods between 1883 and 1892 with 1892 and 1899 we get 166 and 209 respectively, or an annual comparison of 15 to 28, the proportion of men to women being 3 to 1, while the total population of the two periods was 70,000 and 80,000. Suicides have doubled, while the population has only increased one-eighth in the same time. Shooting has increased, while poisoning has decreased. The most common poison was arsenic and cyanide of potassium—opium.

The Operating Theatres.

ST. THOMAS'S HOSPITAL.

PYLORECTOMY FOR CARCINOMA OF THE STOMACH.—Mr. ANDERSON operated on a young woman, æt. 29, for carcinoma of the pylorus. The patient, an emaciated woman, had suffered from symptoms of dilatation of the stomach, with pyloric obstruction for nine months. When admitted she was suffering from daily vomiting occurring about half-an-hour after food, and on examination of the right side of the epigastric region a hard rounded mass about the size of a large orange could be felt immediately beneath the parietes. This was freely movable within a radius of two or three inches; the stomach beyond could be detected by palpation in a state of dilatation. The patient was extremely feeble and emaciated. A diagnosis was made of cancer of the pylorus, and the woman consented to an abdominal section. A vertical incision was made through the inner part of the right rectus, and on opening the abdomen a mass of carcinoma became at once visible; it was found that this involved the pyloric end of the stomach, but it was freely movable and could be drawn outside the abdomen. No enlarged glands could be felt. The stomach and duodenum on either side of the tumour were secured by clamps, and the whole mass was excised with a fair margin of apparently healthy tissue. The opposed cut borders of the duodenum and of the stomach were sutured strongly with silk, the needle passing through all the coats and bringing peritoneum to peritoneum, the intervals between the stitches being larger on the gastric than on the duodenal side, thus allowing the two tubes to be united without leaving any surplus portion of the stomach to be dealt with separately; an extra row of Lembert's sutures was then applied to the anterior surface, and to as much of the posterior surface as could be reached. The ex-

ternal wound was then closed. The operation occupied about an hour, and the patient showed no sign of shock. Mr. Anderson remarked that the case appeared to be a very suitable one for pylorotomy, because of the mobility of the growth which permitted its withdrawal from the abdomen, and also because of the absence of obvious glandular implication as well as on account of the youth of the patient. The system of sewing adopted was, he thought, fairly speedy and gave a very firm hold upon the coats of the viscera, and the means adopted for adapting the larger and smaller sections appeared to offer the advantage that no surplus stitches were required for any portion of the stomach. The prognosis might, he said, be considered good, as the operation involved no shock; there was, however, of course, a possibility of recurrence from some undetected glandular infection.

Ten days after operation it is satisfactory to state that the patient is progressing well and is fed entirely by the stomach.

REMOVAL OF PART OF THE THYROID WHICH HAD UNDERGONE CYSTIC DEGENERATION.—MR. BATTLE operated on a woman, æt. about 58, of stout build, who had been sent to him for dyspnoea, which was becoming urgent in its nature. She gave a history of six years or more of swelling in the neck, with a more marked increase in size during the last few weeks, when the patient had first begun to suffer from difficulty in breathing. Latterly this difficulty had become so marked that she was unable to lie down. Her face was rather dusky, and her inspiration heavy and difficult. Her voice was also changed in character, and she had a difficulty in making herself heard. The neck was a good deal enlarged, especially in front, and it was evident that most of this was due to a cystic enlargement of the left half of the thyroid, and the larynx had been displaced to the right two inches from the middle line. Although there was well marked fluctuation in the thyroid swelling it was not particularly tense and hardly appeared to account for the great displacement of the larynx, and it was suggested that this might be due to a development of other cysts deeper in the neck than the one which could be felt. At the operation when the patient had been placed under chloroform an incision was made along the left side of the neck in front of the sterno-mastoid, and deepened until the cyst wall had been cleared. This involved division of the omo-hyoid muscle. It was then attempted to shell out the cyst from its capsule, but the diseased gland passed so far downwards that the lower part of it could not be reached with the finger introduced through the wound. An opening was therefore made in the large cyst and its serous-looking contents evacuated. By cutting on the cyst wall, the tumour was lifted somewhat, and after incision of another cyst which contained fluid in which cholesterine crystals were evident, the separation of the surrounding parts from the remainder of the tumour was effected, and it readily came away from its attachments towards the isthmus of the thyroid. The portion removed was partly cystic and partly solid, and measured at least five inches from above downwards. It had extended behind the sternum and clavicle, and the movements of the lung above the first rib were startlingly shown. There was comparatively little bleeding. A few ligatures were required. The omo-

hyoid was sutured and the wound closed with interrupted sutures, a drainage tube being placed in the lower part. The removal of the tumour was followed by relief to the respiratory symptoms. It may be noted that the trachea in this case although partly exposed after removal of the tumour did not appear to be particularly softened, and had resumed its normal shape when examined. Mr. Battle remarked that it was a case of considerable gravity, for the patient's life was directly threatened as result of the pressure of the tumour, her face showing signs of venous congestion, whilst occasional cough with mucous expectoration indicated the condition of the bronchi below. The operation was a somewhat difficult one, he said, on account of the unusual size of the swelling, and for a time it was a question as to the best way to get the tumour out. After the cysts had been emptied the more solid part of the growth came forward and upwards, and, by keeping on the cyst wall, separation was quickly completed. Apparently the disease was one affecting the whole of the left lobe, but there was no evidence of other than a simple degenerative change without malignancy.

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"SALUS POPULI SUPREMA LEX."

WEDNESDAY, JUNE 27, 1900.

A MÆDIEVAL VERDICT.

THE result of the libel case brought by a certificated nurse against a London medical man comes as a startling surprise at the end of the nineteenth century. The facts of the case are simple. The plaintiff, Miss Agnes Dowling, secured a verdict for damages against Mr. L. F. Dods, for a libel contained in a certificate of unacy addressed to the relieving officer for Paddington. In that document it was stated that plaintiff had hallucinations; she said she was bewitched and hypnotised, and had sent threatening letters to various people, some of whom went in terror of their lives. The chief evidence in support of the defendant's plea of justification was that given by the plaintiff herself. That lady entered the witness-box, and

did the defendant write to the relieving officer without malice? To the question whether the defendant acted with reasonable care and with good faith, they answered categorically that the statements in the certificate were untrue. This extraordinary verdict is in accordance with the spirit of mediæval times, when persons were hanged and burned for witchcraft. That such a superstitious attitude could be countenanced in an English court of law at the end of the nineteenth century would be incredible were it not that such a thing has come to pass. Henceforth there can be no security for any medical man who grants a medical certificate of lunacy founded upon subjective symptoms of insanity. The person suffering from delusions and hallucinations need only say he acted under pressure of occult influence, and who shall say him nay? If a telepathist be able to throw his victim down in the street half a mile off he can just as readily make him stab the nearest living creature. A more ridiculous and dangerous verdict, in our opinion, has never emanated from a modern court of law than that delivered in *Dowling v. Dods*. At the same time we may say that the defendant hardly appears to have acted wisely in furnishing such a document at the request of persons who knew plaintiff. The document was not, strictly speaking, a lunacy certificate. It was a confidential communication addressed to the relieving officer, who had no right whatever to communicate its contents to other persons. Had he kept the letter private no question of libel could have been raised. It is with a feeling of relief that we learn that a stay of execution has been granted with a view to an appeal.

CORONERS AND DEATHS UNDER ANÆSTHETICS.

WE have long felt that, sooner or later, coroners would be constrained to investigate the circumstances of deaths under anæsthetics in a less perfunctory manner than has hitherto been the rule, and we learn with considerable satisfaction that Dr. Danford Thomas, the coroner for Central London and Middlesex, has drawn up a series of questions to be put to medical witnesses in such cases. These questions deal with the choice of the anæsthetic, the place in which it was given, and various circumstances attending the administration, such as the temperature of the room, the condition of the patient, and the nature and duration of the anæsthesia. Incidentally an endeavour will be made to ascertain the previous experience of the anæsthetist, the quantity of the drug used and the method of administration, as well as all circumstances and conditions bearing thereon. The objection is certain to be raised that the coroner's court is not the proper place for such technical matters to be inquired into, and it must be conceded that the process of questioning will add considerably to the mental discomfort of medical men who are unfortunate enough to be responsible for these catastrophes. At the same time it may fairly be asked what alternative is available. Week by week as we record under the stereotyped heading of

"Death under Chloroform," additions to the interminable list of fatalities we have occasion to express our regret that, in the vast majority of instances, no details are forthcoming as to the mode of administration and the quantity of the anæsthetic used, in fact there is a total absence of the very items of information which alone will enable us to decide what is the cause of the fatality, or at any rate what are the circumstances and conditions under which these disasters occur. Years have passed and no serious attempt has been made by professional organisations to determine the reasons for this mortality which we strongly hold to be in large measure preventible. In spite of the meagre nature of the available data it is, we believe, indisputable that the overwhelming majority of the deaths under chloroform take place when the so-called "open" method has been adopted, a method which is comparable to that of the careless dispenser who guesses at quantities instead of measuring or weighing. Chloroform has the reputation of being a dangerous anæsthetic, and so, doubtless it is, when incautiously administered, simply because it is by far the most powerful of this class of therapeutical agents. That we shall ever succeed in abolishing anæsthetic mortality, even by the use of the most improved inhalers, is not to be expected. Just as the use of a measure is not *per se* an absolute safeguard against giving an overdose of strychnine, so the most trustworthy inhaler will not prevent the exhibition of too strong a vapour. One advantage of a systematic method of questioning medical witnesses, an example which we hope will be extensively followed by coroners all over the country, is that in time we shall collect a body of evidence which cannot but assist us in arriving at definite conclusions, one of which, we feel sure, will be the imperative necessity of forbidding the administration of the drug on a towel or handkerchief except in cases of emergency which it will be the duty of the anæsthetist to justify. Another result may not improbably be that no one will be allowed to administer an anæsthetic until he has learned to employ a regulating inhaler, because inexperience of the use of such apparatus is certain to lead to the easier but the more risky method being preferred. The suggestion that the answers to the questions should be treated as confidential is beside the mark. It is impracticable because it is, we imagine, not within the discretion of the coroner to limit publicity, and it is undesirable because the knowledge that these questions will have to be answered will certainly enhance the sense of responsibility which every medical man already feels when called upon to discharge this important function.

THE subject for the essays for the Howard medal of the Royal Statistical Society to be awarded in 1901 is "The History and Statistics of Tropical Diseases with Special Reference to the Bubonic Plague." The essays must be received on or before June 19th, 1901.

Notes on Current Topics.

The Sanitary Condition of Furnished Houses.

THE case of Harman v. Simpson, which was heard before Mr. Verey, Official Referee, in the High Court on Friday, the 15th inst., raised important points regarding the standard of sanitary condition covered by the implied warranty given by the landlords when letting furnished houses. The defendant agreed to take a furnished house, 33, Pandora Road, Hampstead, from the plaintiff for twelve months, but on being advised by his sanitary surveyor that the house was unsafe as a place of residence, he declined to take the house. The sanitary inspector of the Hampstead Vestry was called for the plaintiff. He gave it as his opinion that the sanitary arrangements of the house were satisfactory, and equal to 99 out of every 100 houses in Hampstead. The following facts were admitted by witnesses on both sides:—W.C. on bedroom floor not against an external wall; this w.c. had an earthenware trap with putty joint at connection with soil pipe; the soil pipe was of light iron rain-water piping, rusty, and with putty joints—also in the centre of the house throughout its whole course; there was no disconnecting trap with air-inlet between the sewer and the house, and the only ventilator to the drain was the iron soil pipe already mentioned. In cross-examination the Vestry inspector admitted that in consequence of a complaint made in January he tested the soil pipe and found a defect, which he saw made good that in February a further complaint was made, and on again testing the soil pipe he found two new defects; these he saw made good. In May Mr. Simpson agreed to take the house furnished, but before entering into occupation had a sanitary survey made, the result being that the house was condemned; and on behalf of the defence it was said that a w.c. and soil pipe as described were dangerous to health, and it was urged that the evidence of the vestry inspector proved that a thin iron soil pipe with putty joints could not be relied upon even from month to month, defects not existing in January having been discovered in February. This view, however, did not commend itself to the Official Referee, and judgment was given for plaintiff for £70 damages.

A Sterilised Milk Service for the Poor.

THE question of infantile mortality is one that may well exercise the mind of the sanitarian. There can be no doubt whatever that improper feeding lies at the root of the matter, both as a direct cause of death and still more often as a predisposing factor that lowers the resistance to the invasion of acute disease. A practical step, therefore, is to raise the standard of purity of the food of the children among the working classes. From the necessities of the case the mothers have often to spend most of their day at work away from their homes, so that the babies cannot be fed from the breast. In order to meet this state of matters some of the towns in the north of

spired which throw doubts on the justice of the verdict. These facts were brought before the Home Secretary, but that official did not deem it necessary to take any action in the direction of reducing the sentence. Mr. Justice Grantham refused the *mandamus* on the ground that to grant it would be to place the Council in the position of judge and jury in a most difficult and complex case. He confirmed the action of the Council in having refused to postpone taking action in the case on receipt of the certificate of conviction, and intimated that though the Council had a discretion to rehear, it was not incumbent upon it so to do. We do not quite understand why Mr. Bynoe applied to the Court, because if he could make out a *prima facie* case for revision of his sentence the Council would doubtless have lent a willing ear. On the other hand it would place the Council in an invidious position to rehear, and virtually to retry, a case on evidence which apparently did not weigh with the Home Secretary. We fear that it will first be necessary to take steps to get the sentence reversed in order to give the Council grounds for modifying the *status quo*.

The Insolation Catastrophe at Aldershot.

THE unprecedented disaster which befel the troops in training at Aldershot a few days since belongs, like so many of the disasters which have befallen our troops in the field, to the eminently preventible variety. Hot days are not altogether unknown in June, and the provision of suitable headgear is precisely one of the things that a reasonable administration would have taken care to secure. The arrangements as a whole seem to have been a hopeless bungle, for not only were the men marched out regardless of the overwhelming heat and the absence in great part of proper covering for the head, but the commissariat department appears to have miserably failed to fulfil its functions. What can a sprinkling of medical officers do when suddenly confronted with several hundred cases of insolation or heatstroke? Obviously very little, for in such cases moments are precious and instant refrigeration is imperative as it is unobtainable. Such an occurrence is disheartening, and we trust that the responsibilities will be brought home to the persons to whose want of foresight and organising capacity the disaster is directly attributable.

Another Lunacy Action.

IN an action tried last week in the Queen's Bench Division a coachman brought an action for damages against Dr. J. Hill Gibson and Dr. M. Young, who practise in partnership in Maida Vale, for professional negligence in that they had certified him to be suffering from melancholia, whereas on being removed to the infirmary he was discharged three days later as sane. There was ample evidence that the plaintiff was much upset at the prospect of an addition to his family, and had made use of language calculated to convey the impression that he contemplated injury to others as a preliminary measure to self-destruction. After some sympathetic remarks

by the judge, the jury found a verdict for the defendants. All's well that ends well, but who will compensate these gentlemen for the worry, expense, and annoyance of having to defend this action. An impression has gained ground that a medical man acting in such a matter with reasonable care, would be protected by recent legislation against vexatious proceedings. Recent events seem to prove that such is not the case, and we are again within measurable distance of concerted refusal on the part of practitioners to grant such certificates which, in exchange for a paltry fee, entail unlimited risks.

Mercury in Heart Disease.

IN many cases of heart disease the most pressing demand on the skill of the medical attendant is the necessity of reinforcing cardiac contraction and of reducing the amount of work thrown upon that organ. The attention devoted to the fulfilment of the first of these two requirements seems in many cases to result in a very perfunctory attempt being made to arrive at a successful issue in the direction of the relief of the heart from work. The soluble preparations of mercury do more than act as purgatives, increasing intestinal mucous secretion and enforcing the contractions of the muscular coats of the bowel, for they exert a further action on the system of arterioles and capillaries. The connection between this collateral action of mercurial purgatives and the relief they afford to the engorged heart is undoubted, but its therapeutical significance is nowadays neglected in a large number of cases. There is reason to believe that the usual methods of administering mercury result in the drug assuming but one form only in the blood and its elimination has certainly been traced in all the secretions, physiological and pathological; its area of effectiveness is therefore widespread, and one notable benefit derived is the reduction of arterial tension, thus lowering the peripheral circulatory resistance and easing the cardiac stress. The ingenious hypothesis that mercury acts on the chemical conditions of the liver and aids in the elimination of certain impurities in the blood which tend to heighten capillary resistance is certainly satisfactory as far as it goes, but in an urgent cardiac case, when by mercury the medical attendant has reduced the swollen liver by depletion of the portal system, and diminished the arterio-capillary tension, the refreshing sleep that often follows is a far more encouraging fact. The diuretic effect of mercury in the treatment of heart affections is now beginning to receive the support it merits, and it is astonishing how the intelligent exhibition of mercury in suitable cardiac cases, combined with the well-known heart tonics will enable a practitioner to tide his patient over many an otherwise alarming illness.

Treatment of Threatened Asphyxia.

THE announcement that Dr. R. L. Bowles is to give three lectures at the Medical Graduates' College and Polyclinic in the beginning of July on "Some Practical Points in the Treatment of Threatened Asphyxia" recalls the fact that no final report has

yet been received from the Committee appointed by the Royal Medical and Chirurgical Society on the subject of the resuscitation of the apparently drowned. This Committee was the outcome of a paper read by Dr. Bowles in June, 1889, and after the lapse of so many years the report when it is issued will no doubt contain the results of the Committee's labours during such a lengthened period. It would appear, however, probable that in the lectures Dr. Bowles is announced to give, all the information concerning the merits and demerits of the different methods of resuscitation will be brought up-to-date and presented in such a way that some useful deduction may be drawn not only of interest to the medical theorist but also of practical utility in saving life. If the instructions of the Royal Humane Society are not the best that can be issued under the circumstances, then the sooner the matter is taken in hand and the difficulties faced and overcome the better it will be for all concerned.

The Galway Hospital as a Clinical School.

SOME months since a crisis occurred in the affairs of this institution. Previous to that time the workhouse hospital was conjoined with it in affording clinical instruction to the students of the Queen's College, but then the privilege of attending that infirmary was withdrawn by the Guardians, the students being thus left without one of their centres of teaching. This was done by the Guardians, as far as we have been able to ascertain, not because of anything said or done by the medical staff or by the Queen's College or by the students, but in consequence of the usual politico-religious row which governs such details in Ireland. The L.G.B. for Ireland, in conformity with their new and universally applicable nursing rule, ordered the appointment of a trained nurse for the hospital, the training to be as defined by the Board, while the Guardians of the Union wished to appoint a nun who had not been so trained. As we understand, the Governors of the hospital had no alternative but to select someone who would receive the approval of the Local Government Board, and they did so, with the result that the Guardians visited their rancour on the students by withdrawing the clinical use of the workhouse infirmary in the hope that the students would thus be prevented from pursuing their studies at the hospital. This, of course, placed the Queen's College and its students in a difficulty, and they were compelled to go to the licensing bodies to ascertain whether they would accept as sufficient the certificates from the Galway Hospital *per se*. The Senate of the Royal University agreed to do so, but the Council of the Royal College of Surgeons declined to consider the matter until their representatives had inspected the hospital. Two of the Council were deputed to do so, and, on their favourable report, the Council of the College agreed to accept the certificates of the past winter session, but for no longer, assigning as their reason that it would be a great injustice to the students to deprive them of the opportunity of presenting themselves for the examinations when they

Lannelongue and Brouardel, and a convenient room has been placed at their disposal. The list of entertainments, which we were able to announce in our last issue, is now complete by the addition of a grand fête to be given by the Town Council of Paris in the salons of the Hôtel de Ville on the evening of August 7th.

The Queen's County Infirmary.

On the 15th of this month Dr. William Gardiner Jacob, who was recently ousted from the Surgeoncy of the Queen's County Infirmary by the dominant party in the new County Council, was presented with a cheque for £352 10s. as a testimonial of sympathy and of public approval of his services to the Infirmary and to the public. The address which accompanied the gift says:—

"It is to your several friends a matter of no slight gratification to find that the testimonial has been so widely and liberally supported. It has been, by far, the most generously subscribed to an object of its kind in the Queen's County of recent years; but we have no doubt you will chiefly appreciate the compliment now sought to be paid you by your numerous friends and well-wishers, owing to the circumstance that the testimonial has been supported by all classes and creeds irrespective of either party considerations or politics."

This statement is borne out by the presence among the names of those who subscribed to the testimonial of many who differed widely from Dr. W. Jacob in most subjects save the performance of his professional duties, and especially by the fact that the Working Man's Club sent a cheque for £13 10s. in witness of their appreciation of Dr. Jacob's work among them. We warmly congratulate him upon the well-deserved compliment thus paid to him.

Employment for Epileptics.

THE experiments of Pastor Bost commenced some fifty years ago at La Force, near Bordeaux, and the establishment of the famous Bielefeld Colony in Germany were the means of the foundation of the Chalfont Colony for Epileptics, and the report just issued of the work done during the five years of its existence more than justifies the hopeful expectations expressed in the earlier years of the Colony's existence as to the usefulness of, and the benefits to be obtained from, the Colony system for the employment of epileptics. From a medical point of view there is much interest attaching to the statement that the influence of the colony system upon the women epileptics is remarkable, the improvement being considerably more apparent than in the case of the male epileptics of adult age.

The President and Council of the Medical Graduates College and Polyclinic have arranged for a *conversazione* to be held at the college in Chenies Street on Wednesday, July 4th. There will be a reception by the President at 8 p.m., and an address on "The Teaching of Practical Medicine," to be delivered by Professor Osler, F.R.S., of Baltimore, at 9 p.m.

Erythropeia.

THE curious affection termed "red vision" or erythropeia has been noticed lately in the medical press, and in one instance reported by Dr. Gabe, the cause was assigned to staring at the sun on the occasion of the last eclipse without the intervention of smoked glass. In Dr. Gabe's case the patient is reported to be possessed of normal vision and is not the subject of cataract. This uncommon ocular disturbance is noticed to occur with much greater frequency in people who have suffered removal of the crystalline lenses for cataract, and statistics show that one-third only of the individuals affected possess normal eyes. The attack appears to be brought on by the conjunction of two factors, a high state of mental excitement and exposure to strong illumination of the retina. In the case just referred to, the symptom was only observed for three evenings, but the rarity of this ocular trouble and the utter absence of any reasonable explanation of its ætiology render all cases of the kind worthy of record.

Symptomatic Treatment versus Cure.

IN certain quarters the decline of the serious study of pharmacology among the younger generation of medical men is made the subject of strenuous complaint. The fact of the matter seems to be that the attitude in question results from a reaction. The pendulum has swung from a bewildering mass of detailed statements about the action of drugs to an opposite extreme of cynical unbelief. There appears, indeed, to be more or less truth in the assertion that the less our knowledge of disease the greater our number of drugs. Turning to the incurable condition locomotor ataxia, in a recent authority we find a formidable list of ways and means of symptomatic and other treatment. The sclerosis is to be treated by iodides, or if those be not tolerated by silver salts. Antisclerotic diet, whatever that may be, is held to be important. Electrotherapeutics and suspension are advocated in chronic stages. A number of remedies are mentioned for the various crises. For deficient muscular power injections of artificial serum and glycerophosphates are to be given, together with tonics and massage, hydrotherapy, electricity, and mineral waters. For ataxia re-education of muscles by movements, as in Frankel's method, is advocated. Other directions include suggestion, methylene blue, spinal cord extract, Brown-Sequard fluid, nitrate of silver, and nuxvomica. Yet in spite of it all locomotor ataxia remains an incurable condition. In the United Kingdom, at any rate, the suspension treatment has long been discredited. The pharmacologists appear to have somewhat injured their own cause by a too dogmatic claim of the therapeutic control of disease by drugs.

A PORTRAIT of John Abernethy, painted by G. Dance, R.A., has recently been acquired by the trustees of the National Portrait Gallery.

THE number of persons who have expressed a desire to attend the Summer School of Medicine at Cambridge has been so small that it will not be held.

THE committee of the Imperial Yeomanry Hospital have, much to their regret, received a telegram reporting the death from enteric fever on Friday last at Deelfontein of Mr. Richard Truman FitzHugh, M.B., M.R.C.S., L.R.C.P., surgeon on the staff of the Imperial Yeomanry Base Hospital.

PERSONAL.

PROFESSOR OLIVER LODGE has been appointed the first Principal of the University of Birmingham.

THE M.D., M.Ch. of the University of Dublin are to be conferred on Sir William MacCormac *honoris causa*, to-morrow (Thursday.)

MR. J. A. BLOXAM's name has been added to the list of candidates for election to the Council of the R.C.S.E. Mr. John H. Morgan has withdrawn.

MR. WILLIAM BERRY, the senior honorary surgeon and secretary of the Medical Board of the Wigan Infirmary, has been elected chairman of the General Board for the ensuing year.

AN English lady, Miss Hamilton, has just been awarded the *digna entrare* of the Medical Faculty of Montpellier. Her thesis for the doctorate was a study of the present nursing system in France.

DR. ELLERY, who has been practising in Plympton for more than a quarter of a century, was presented last week, on the occasion of his leaving for Dawlish, with a silver salver, and Mrs. Ellery with a purse of gold, as a mark of esteem on the part of the inhabitants.

MR. COLIN GIFFARD, the senior prefect of Epsom College, has been awarded the "Wakley" prize, founded by the late editor of the *Lancet* for "the best fellow all round" of the school, the election being made by the boys themselves. Mr. Giffard also secured the prize for elocution.

A TELEGRAM to the *Daily Express* yesterday reports the death from blood-poisoning at Hartford, New England, of two well-known surgeons, Dr. E. E. Leonard and Dr. Melancthon Storrs. After performing a successful operation for empyema on a patient, symptoms of blood-poisoning developed, to which they both succumbed.

AMONG the Europeans at present beleaguered in Kumasi are the following members of the Colonial Medical Service:—Patrick Joseph Garland, senior assistant colonial surgeon, Gold Coast; Mr. Edward Herbert Tweedy, Mr. Albert John Chalmers, M.D. Vict., Mr. William Medlycott Graham, M.B. Dub., and Mr. J. B. Hay, M.B. Edin., assistant colonial surgeons, Gold Coast; the sixth being Mr. W. F. Macfarlane, assistant colonial surgeon, Lagos.

Scotland.

[FROM OUR OWN CORRESPONDENT.]

THE RESIGNATION OF PROFESSOR KENT.

THE various medical teaching centres in Glasgow have recently lost many members of the staff from different causes. St. Mungo's College is now to lose the services of Professor Kent, B.A., F.R.C.S., holder of the Bellahouston Chair of Anatomy, who has intimated his resignation.

retary. A *conversazione* was held at the Owens' College, several garden parties were held, and some of the members started on Saturday for an excursion to the Lake district.

CHEMISTS' EXHIBITION.—An admirable display of pharmaceutical preparations and materials, interesting alike to the chemist and medical practitioner, has just been held in St. James's Hall. Many of the large firms were well represented, and several medical publishers displayed their books. This is the first time the Chemists' Exhibition has been held outside London, but we venture to think it will not be the last time it comes to Manchester.

Correspondence.

We do not hold ourselves responsible for the opinions of our correspondents.

THE ROYAL COLLEGE OF SURGEONS IN IRELAND.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Will you be kind enough to give insertion in your next issue to the following address, and oblige?

I am, Sir, yours truly,

A. H. JACOB, F.R.C.S.I.

To the Fellows of the Royal College of Surgeons in Ireland.

Gentlemen,—At the conclusion of the meeting of the College on the 2nd of June last, and in the presence of less than 20 Fellows, the following Resolution, of which the terms were not previously known, was hastily adopted:—

"That it be a direction to the Council to ascertain, by means of a circular sent to each of the Fellows, whether they would wish, with the object of discouraging canvassing, that the Council should, immediately after an election to the office of president or vice-president, recommend to the College the name of one Fellow for election to the next ensuing vacancy in each of these chairs. That in case the majority of the replies received are in the affirmative the Council shall act in compliance of with the wish of the Fellows so expressed."

In compliance with this resolution you will shortly receive the circular from the Council, and my purpose in addressing you is to explain the result of the arrangement if carried into effect, and to urge you to discountenance it in every way in your power. Please observe that the issue of the Council's circular does not imply any acquiescence in the proposal, the propriety of which has never been considered by them. The declared purpose of this proposal is to discourage canvassing. While I recognise that it is impossible, and an undue interference with personal liberty to seek to forbid reasonable solicitation for votes, I am in sympathy with any arrangement which may make impossible the abuses of solicitation which may amount equally to an interference with private judgment and with the privacy of the ballot. I submit, however, that the proposed arrangement would have no such desirable result, because:—

1. While it professes to restrain canvassing for the presidency and vice-presidency, it leaves unrestrained the importunity of the numerous candidates for the 9 seats as councillor which, from the multiplicity of the competitors and the urgency of the contests is liable to be most oppressive upon the Fellows.

2. The proposed selection of president and vice-president by a majority of the Council could never be operative as anything more than a recommendation, inasmuch as the right of any Fellow to offer himself and to be voted for is secured to him by the College charters, and could not be restricted by any act of the Council. It is, therefore, most probable that any Fellow seeking such office, and feeling aggrieved at not having been selected by the Council, would proceed with his canvass in defiance of their selection, and might succeed in ousting the Council nominee, to the great humiliation of that body.

3. The proposition is that "immediately after the election of a president or vice-president the Council should" proceed to nominate to the next succeeding

vacancy (certainly for one year, practically for two years, in advance), a suggestion which, I submit, is impracticable.

4. Assuming that the Fellows would be willing to leave the nomination of the two chief officers of the College to eleven or a less number of the Council, it would be disastrous to do so inasmuch as so small an elective body would be sure to be dominated by school, or political, or personal, or religious influences, and the candidates best for the collegiate interests would be liable to be passed over. Nor would it be any honour to sit a President or Vice-President by the will, not of the Fellows at large, but of a clique.

Brother Fellows,—You are now endowed with the fullest and freest control of your College, whose administrators you appoint or dismiss once a year according to their deserving, and I respectfully warn you not to part with any shred of that control or of your elective power. Many of you may not know that before the year 1844 the College was administered in all its functions by an oligarchy, some of whom availed themselves of their control over the educational requirements and examinations of the College to make considerable fortunes from apprentice fees. At length the thing became so great a scandal that the outside Members and Licentiates started, in 1839, an agitation which attained such force as to bring about the radical reformation of the constitution of the College. The supplemental Charter of 1844 thus enacted took the elective power out of the hands of the oligarchy of eight, abolished apprenticeship fees, and substituted genuine education and examination as the sole qualifications for the collegiate licence. But the new Charter did much more than this. It transmuted the Members, who had, practically little influence over the College, into the Fellows of whom you and I have the privilege to be units, and it invested them with the most comprehensive and democratic control over the *personel* of the Council. It is this change which has given strength to the College and enabled it to keep its place not only as a constituent item but as a prominent leader among medical authorities in all professional matters. I urge you not to do anything which will even have the appearance of delegating your elective authority to any conclave, however respectable, for if you do not see fit to exercise that authority, it will at least be well for you to keep it in hand for use when wanted.—Yours respectfully,

ARCHIBALD HAMILTON JACOB, F.R.C.S.I.,
23 Ely Place, Dublin. Senior Member of Council.
June 24, 1900.

THE FELLOWSHIP OF THE ROYAL COLLEGE OF PHYSICIANS, LONDON.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—Your correspondent, "An Indignant Member," has answered his superior officer in a way that must have somewhat disconcerted that worthy gentleman. Three more glaring instances of negative injustice could not have been advanced. At the same time perhaps one may be permitted to ask whether the "Indignant Member" has taken steps to ascertain whether the gentlemen mentioned have or have not had the Fellowship actually offered to them by the College of Physicians of London. It is not known to all the world that the honour of Fellowship is saddled with a considerable money tax. The fees payable by the recipient amount to about 90 guineas, from which the membership fees are remitted. The honour, therefore, is to that extent a matter of purchase.

That a scientific distinction of this kind should be in the hands of a small clique and made a matter of traffic is a rank anachronism at this time of day.

I am, Sir, yours truly,

AN AMUSED MEMBER.

Exeter, June 20th, 1900.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The two letters from an "Indignant Fellow," on the subject of his College are rather amusing, and they certainly lead one to reflect upon the College, if most of the Fellows are similar in sentiments and in personal

character, so far as one can judge of the latter, to the Indignant Fellow. It looks as if he felt more proud of the "honoris" than of the "causa" for which the Fellowship was given him; and he may be wise in taking such a view of the F.R.C.P.

If the F.R.C.P. is to be used as a kind of advertisement, as appears to be the case with this as with many other societies, it is not of so much the "honoris causa" as "pecuniæ causa," so that when a man tries to get the Fellowship it may fairly be assumed that he has an eye to business:

I am Sir, yours truly,

NON-INDIGNANT.

London, June 20th, 1900.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—The absurdity of an "Indignant Fellow's" contention that the F.R.C.P. is never unduly withheld nor improperly bestowed, is evident to anyone who knows anything as to how the Fellowship is granted. It is bestowed *ipso facto* on every physician after serving seven years on the staff of a metropolitan hospital with a teaching school. The man may or may not be able, that matters nothing. A very much more able man, who never had the luck to get attached to a teaching school, but who is on the staff of a London hospital, may be kept waiting many years for his Fellowship, or he may never get it at all.

The greatest bar to getting the Fellowship is success in practice as a member. That Dr. MacLagan has never been elected a Fellow is a scandal, and demonstrates to everyone the petty jealousy which governs the actions of the so-called leaders of the profession. Dr. MacLagan's is by no means an isolated case. The late Dr. Cumberbatch, a distinguished and successful physician, was never elected to the Fellowship, presumably because he had a large and fashionable practice.

Have we not, on the other hand, within the last few years, seen the Fellowship bestowed on very junior members of no standing or repute because they had high interest at the college? It is new to me that "only G.P.s. are at the beck and call of everyone," and therefore unworthy of the Fellowship.

Are there, then, no busy men among the Fellows? Are not many of them general practitioners too, masquerading as consultants? I think "Indignant Fellow" is having his joke in the last paragraph of his letter. To think of the College of Physicians as one of the mainstays of society and the upholder of social distinctions! It is too funny. Does "Indignant Fellow" really suppose that the public know or care anything about the College or its degrees?

I am, Sir, yours truly,

M.D.

London, June 21st, 1900.

"VERIFICATION OF REFERENCES."

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

DEAR SIR,—I thank you for the editorial paragraph as regards *Dermanyssus avium*. I have noted two other points that interest me in this number, but in neither of them do I find such details as will enable me to "verify my references," and I would venture to suggest to you that a little more attention to this in your editorial work would not be amiss. The "Rôle of the Gonococcus" gives interesting particulars on authority of Neisser (N. Y. *Med. News*, but no number or page referred to) and especially Dr. J. A. Shaw-Mackenzie, who is for me by no means a negligible, but a quite intangible, quantity, as I never heard of him before, and I don't know where to find him.

In the paragraph on the spread of the plague there are similarly vague references, not one of which comes home—i.e., enables a weary wayfarer to get home, to the reference. I should be very anxious also to see the "very original article" by Dr. Harry Campbell on "Monogamy and Longevity," though I think it seems rather wild, but I cannot afford to hunt it up in the enormous vortex of contemporary medical literature, without rudder or compass.

BRADSHAW'S "Bathing Places and Climatic Health Resorts," a new edition of which has just made its appearance, is an old friend. It may be bought for the extremely moderate sum of half-a-crown, and contains within its 380-odd pages a veritable mine of information. In a wallet attached to the cover is an excellent map of Europe, with a clear chart of routes by land and by sea. To medical men who are in the habit of sending patients abroad this little volume will be indispensable.

THE Publishers' Association have drawn attention to the fact that some books have recently been published without any date on the title page, which is contrary to the recommendation circulated by them in 1898 to the following effect:—"That the title page of every book should bear the date of the year of publication, i.e., of the year in which the impression, or the re-issue, of which it forms a part, was first put on the market." We are glad to see this movement on the part of the Association, and hope that no difficulties will be thrown in the way of its realisation.

ANOTHER work on the plague (*Die Pest*), has just made its appearance, the authors being Drs. Muller and Poch of Vienna. A melancholy circumstance attaches to this work, inasmuch as the first-named, who was sent to Bombay as a member of the Austrian Commission, died of the disease before he had time to complete his investigations. This has been done by Dr. Poch, and later observations embodied. The work of Dr. Montenegro, of Madrid, whose *brochure* has been translated into English, receives ample confirmation by the publication of Drs. Muller and Poch's work.

BURDETT'S "Official Nursing Directory for 1900" is an extremely useful book, published at 5s. It gives particulars of the conditions of nurses' service, not only in the chief medical institutions of the United Kingdom, but also in many colonial and foreign countries. In this way a ready reference is furnished for anyone seeking a nurse's or a probationer's post, whether free, paying, or paid. The latter half of the book is devoted to a directory of nurses, and gives details of their training and service. This volume should be extremely useful to all medical men, and indispensable to any institution that employs many nurses.

THE Royal College of Surgeons in Ireland announces that the Barker Anatomical Prize of £21 is offered for competition, and is open to any student whose name is on the anatomical class list of any school in the United Kingdom. The prize is offered for a dissection of the fifth nerve, especially with reference to the Gasserian ganglion. The preparation must be sent to the Curator of the Museums before March 31st, 1901, each being marked with a fictitious signature. No prize will be awarded unless sufficient merit be shown, 70 per cent. of the total marks being the minimum. The cost and risks of transport must be borne by the student.

DR. F. E. DANIEL, of Austin, Texas, has just published his reminiscences of war time, under the title, "Recollections of a Rebel Surgeon," which will doubtless interest many at the present juncture. The author was principally employed in the Southern and Western States of the Confederacy, and his book tells more of the social life of the Confederate surgeon, withal it has many stories, field and hospital experience, cases of malingering among the troops, and the difficulties under which surgeons laboured from scarcity of drugs: chloroform selling at 300 dols. a lb. They are very readable, being told in a bright, chatty way; and throw many kindly lights on Southern life.

THE appearance of a new edition every three years or so of the late Prof. Milnes Marshall (London: David Nutt. 1900) shows that its author succeeded in discovering a want and supplying it; and an addition of only five pages in three editions shows the possession of rare self-restraint. In editing "The Frog," which is

designed as a text book for the course of elementary biology prescribed by the Victoria University, Dr. Fowler has made only a few slight alterations in the deceased author's admirable text, but he has had the illustrations re-engraved, and has substituted a lithographic plate, carefully drawn to scale, of the stages of development, for the picturesque but more popular woodcut copied from Brehm's "Thierleben."

Those very enterprising publishers of directories, Messrs. Kelly, Limited, have just produced the ninth edition of a "Directory of Chemists and Druggists" in the familiar red dress of all their publications. The work before us is more comprehensive than the title might imply, as it contains in addition to chemists and druggists, the names of manufacturing chemists, dentists, veterinary surgeons, wholesale druggists, mineral water manufacturers, photographic material dealers, surgical instrument makers, and other kindred trades and professions throughout England, Ireland, and Scotland, and in this edition the names for the Isle of Man and Channel Islands are included for the first time. So far as we have tested it with names and addresses familiar to us, its correctness is undoubted.

NEW BOOKS AND NEW EDITIONS.

The following have been received for review since the publication of our last monthly list:—

BAILLIÈRE, TINDALL AND COX (London).

A Treatise on Nasal Suppuration and Accessory Sinuses of the Nose. By Dr. Ludwig Grünwald (of Munich). Authorised translation from second German edition by Wm. Lamb, M.D., M.C. Edin., L.R.C.P. Lond. Pp. 335, with coloured plate. Price 10s. 6d. net.

Diseases of the Gall-Bladder, and Bile-Ducts, including Gall-Stones. Second edition. By A. W. Mayo Robson, F.R.C.S., assisted by Farquhar Macrae, M.B., C.M. Pp. 314. Price 10s. 6d. Treatment by Hypnotism and Suggestion, or Psycho-Therapeutics. By C. Lloyd Tuckey, M.D. Aberd. Fourth edition, revised. +p. 376. Price 7s. 6d. net.

Appendicitis, its Pathology and Treatment. By A. H. Tubby, M.S. Lond., F.R.C.S. Medical Monograph Series. Pp. 98. Price 2s. 6d.

A Treatise on Diabetes Mellitus and Glycosuria. By Emil Kleen, Ph.D., M.D. Pp. 314. Price 10s. 6d.

The Philosophy of Voice, showing the right and wrong action of voice in speech and song. By Charles Lunn. Ninth (standard) Edition. Pp. 214. Price 5s.

JOHN BALE, SONS AND DANIELSSON, LIMITED (London).

The Early Treatment of Appendicitis. By Donald W. C. Hood, M.D., F.R.C.P. Lond. Pp. 38. Price 2s. 6d.

CASSELL AND COMPANY, LIMITED (London).

Diseases of the Tongue. By Henry T. Butlin, F.R.C.S., D.C.L., and Walter G. Spencer, M.S., M.D., F.R.C.S. Pp. 475, with eight plates and 36 engravings. Price 21s.

J. AND A. CHURCHILL (London).

A Text-book of Medical Treatment, Diseases, and Symptoms. By Nestor Thirard, M.D. Lond., F.R.C.P. Pp. 692. Price 15s.

Surgery: Its Theory and Practice. By W. J. Walsham, F.R.C.S. Eng., M.B. Aberd. Seventh edition. Pp. 953, with 463 illustrations. Price 15s.

The Cause and Prevention of Decay in Teeth. By J. Sim Wallace, M.D., B.Sc., L.D.S. Eng. Pp. 101. Price 5s.

EYRE AND SPOTTISWOODE (London).

Twenty-Eighth Annual Report of the Local Government Board, 1898-1899. Pp. 588, with numerous plates.

HY. J. GLAISHER (London).

Practical Gynaecology: A Handbook of the Diseases of Women. By Heywood Smith, M.A., M.D. Oxon. Second edition, revised. Pp. 230. Price 5s. net.

CHARLES GRIFFIN AND CO., LIMITED (London).

The Anatomy of the Central Nervous Organs in Health and Disease. By Dr. Heinrich Obersteiner. Translated by Alex. Hill, M.A., M.D., M.R.C.S. Pp. 541. Price 30s.

H. K. LEWIS (London).

A Pocket Medical Dictionary giving the Pronunciation and Definition of the Principal Words used in Medicine. By George M. Gould, A.M., M.D. Fourth edition, revised. Pp. 837. Price 5s. net.

LONGMANS, GREEN AND CO. (London).

A Manual of Surgical Treatment. By W. Watson Cheyne, M.B., F.R.C.S. Vol. III. Pp. 305. Price 12s.

SAMPSON LOW, MARBTON, AND CO. (London).

Twentieth Century Practice of Modern Medical Science. Edited by Thos. L. Stedman, M.D., of New York. Vol. XII.—Malaria and Micro-organisms. Pp. 828.

THE MEDICAL PUBLISHING CO., LIMITED (London).

Lectures on Cleft Palate, Fractures, Diseases of Joints, Treat-

ment of Cancer, Deformities, Hernia, &c. By W. Arbuthnot Lane, M.S. Pp. 344. Price 6s. 6d.

OLIVER AND BOYD (Edinburgh).

Edinburgh Hospital Reports. Edited by G. Lovell Gulland, M.D., F.R.C.P. Ed., and James Hodsdon, M.D., F.R.C.P. Ed. Vol. VI. Price 12s. 6d. net.

SMITH, ELDER, AND CO. (London).

Origin and Character of the British People. By N. C. Macnamara, F.R.C.S. Pp. 242.

SPOTTISWOODE AND CO. (London).

The Medical Register for 1900. Under the direction of the General Medical Council. Pp. 1719.

The Dentist's Register for 1900. Under the direction of the General Medical Council. Pp. 241.

STRAND NEWSPAPER COMPANY, LIMITED (London).

Passmore-Edwards Institutions, Founding and Opening Ceremonies. By J. J. Macdonald, Pp. 93, with 72 4to plates.

JOHN WRIGHT AND CO. (Bristol).

Golden Rules of Ophthalmic Practice. By G. H. Hartridge, F.R.C.S. Pp. 69. Price 1s.

The Wellcome Chemical Research Laboratories.

THE new and recently-completed Wellcome Chemical Research Laboratories situated at 6, King Street, Snow Hill, were opened for inspection on June 18th. The institution is the result of the enterprise of Mr. Henry S. Wellcome, of the firm of Messrs. Burroughs, Wellcome, and Co., and it is an outward and visible sign of the spirit of research which has become so indispensable a factor not only in relation to industrial pursuits, but also in the study of those important problems in medical science so intimately associated with health. The laboratories are designed for investigations in both pure and applied chemistry, and in the latter instance with special reference to the study of that large class of both organic and inorganic compounds employed as medicinal agents in the treatment of disease. The building consists of four stories and a basement, and the visitors were conducted round on a tour of inspection by Dr. F. B. Power, the present director. On the ground floor are the offices of the director and a well-selected library of works on recent chemical and pharmacological studies. The laboratories proper are located on the first, second, and third floor of the building, and are completely equipped with all the necessary apparatus and appliances for conducting chemical investigations. The establishment of this centre for scientific research work will be sure to attract the earnest attention of all those interested in the progress of the applied sciences.

Annual Banquet of British Postal Medical Officers.

UNDER the genial presidency of Dr. W. Dougan, the Association of British Postal Medical Officers held their annual banquet in the Whitehall Rooms of the Hotel Metropole on June 21st. Among the guests were Sir James Crichton Browne, Sir Joseph Fayrer, Mr. Edmund Owen, Mr. J. Walton, M.P., Mr. E. Wayson, Dr. F. de Havilland Hall, Sir George Kekewich, Dr. J. Tatham, Prof. Corfield, Dr. Whitelegge, Dr. P. J. Freyer, &c. The toast list was a very long one, and it was past midnight before the guests dispersed. The evening concluded by a speech from Dr. H. Fitzgibbon, giving the toast of "The Guests," which was replied to by Sir Thomas Roe and Dr. P. J. Freyer. In the course of the evening Miss Lilian Corner and Mr. George Schneider gave excellent renderings of some well received songs.

Death from Tetanus.

A DEATH from tetanus occurred at the Newbury District Hospital last week, the victim being a lad, *et.* 12, who had sustained dislocation of the thumb and a cut head by falling off a horse. The jury arrived at a curious finding, *viz.*, that the tetanus was caused by dislocation of the thumb. Inasmuch as there was a wound of the head through which the virus was conceivably inoculated, it was hardly fair to incriminate the dislocation of the thumb which, unless compound, could not have furnished an entry for the infection.

THE annual prize distribution of the London School of Medicine for Women, 8, Hunter Street, W.C., will be held on Thursday, 28th inst., when the prizes will be distributed to the students of the School by Lady Roberts.

Notices to Correspondents, Short Letters, &c.

✉ CORRESPONDENTS requiring a reply in this column are particularly requested to make use of a *distinctive signature or initials*, and avoid the practice of signing themselves "Reader," "Subscriber," "Old Subscriber," &c. Much confusion will be spared by attention to this rule.

THE BONTGEN RAYS IN MEDICAL AND SURGICAL WORK.

To the Editor of THE MEDICAL PRESS AND CIRCULAR.

SIR,—In reply to Mr. Richard J. Cowen's letter in your issue of June 13th, I can only say that I have not, to any extent, experienced the difficulty referred to by him. It has only occurred once in my hands with the form supplied by Messrs. Isenthal and Co., and amongst my earliest experiments. It is just possible something in the other parts of the apparatus may explain matters. For example, the large 28 inches spark coil, which I use, and made for me by Mr. Max Kohl, of Chemnitz, has more than one primary. The one most frequently employed works with a high voltage and a very low current.

I am, Sir, yours faithfully,

J. MACINTYRE.

179, Bath Street, Glasgow, June 25th, 1900.

M. T. BIRCH.—Your communication is quite un-uitable for our columns. It, moreover, contains assertions at variance with our knowledge, and quotes as authoritative the opinions of a person unknown to medical science.

URBAN AMBULANCES.

Apropos of your Editorial Note on the above subject (writes our Paris Exhibition Commissioner), I have seen some excellent ambulances here, notably those used by the Assistance Publique for accidents, infectious, and maternity cases. There are also excellent examples of military ambulances. But we have no reason to go abroad for these very necessary adjuncts to civilised life in big cities. I noticed a beautiful exhibit made by Messrs. Wilson and Stockall, of Bury, Lancs., who show a brougham ambulance for conveying sick and also infectious cases, and a Red Cross ambulance for accidents. They are splendid specimens of carriage work; light, strong, elegant, and finished in most careful style. Such ambulances, supplemented by good types of hand trolley ambulances, should be provided by every urban authority, for they are quite as necessary as dust or watering carts.

Meetings of the Societies and Lectures.

THURSDAY, JUNE 28TH.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.—5 p.m. Dr. F. W. Mott: The Degeneration of the Neurone (Croonian Lecture). Lecture IV. Syllabus:—Primary Degeneration. The Arguments in Favour of General Paralysis being a Primary Degeneration with Secondary Inflammatory Changes.—Primary Degeneration may Affect the Afferent System as in Tabes, the Efferent System as in Amyotrophic Lateral Sclerosis, or both Afferent and Efferent Systems as in Combined Sclerosis.—Observations upon Multiple Polyneuritis due to Alcoholism. The Effect of Stress in the Production of Degeneration. The Important Influence of Heredity in Nervous Diseases. The Influence of Alcohol, Syphilis, and Tuberculosis upon the Germinal Plasma, and the Effects upon the Offspring in the Production of (a) Premature Decay of the Neurone, (b) Arrest of Development of the Neurone. Juvenile General Paralysis Studied in 30 Cases. Congenital Imbecility and Epilepsy from 40 Cases.

Appointments.

BLOWFIELD, A. B., L.R.C.P.Lond., M.B.C.S., Medical Officer for the North Peckham Sanitary District of St. Giles, Camberwell.
CLARKE, H. W., L.R.C.P.Lond., M.B.C.S., Medical Officer for the Chapel Sanitary District of the Dorking Union.
COLLIER, JAMES, M.D., B.C.Lond., M.B.C.P. Pathologist to the National Hospital for the Paralyzed and Epileptic, London.
COLTS, P. C., L.R.C.P.Lond., M.B.C.S., Senior House Physician to King's College Hospital, London.
DEPREZ, SIDNEY S., M.B., Ch.B., Senior House Surgeon to the Bootle Borough Hospital, Liverpool.
EDWARDS, C. W., F.R.C.S.Ed., L.R.C.P.Lond., M.B.C.S., Medical Officer for the Temple Coombe Sanitary District, Wincanton Union.
EVERINGTON, H. D., M.B.Lond., L.R.C.P., M.B.C.S., Resident Medical Officer to the Royal Hospital for Children and Women, London.
FENN, C. E., M.B.Durh., L.R.C.P.Lond., M.B.C.S., House Surgeon at King's College Hospital, London.
GOULDEN, H. E., L.R.C.P.Lond., M.B.C.S., D.P.H.Cantab., Medical Officer for the Fifth Sanitary District of the Honiton Union.
HAINES, WHEELER, B.S.Lond., M.B.C.S., L.R.C.P.Lond., Senior Assistant Medical Officer to the North Riding Asylum, Clifton, York.
HEHN, William, M.B.C.S., L.D.S., Dental Surgeon to the Middlesex Hospital, vice Storer Bennett.
HUNTER, DAVID, M.A., M.B., B.C.Cantab., Medical Superintendent of the New West Ham Borough Asylum at Chadwell Heath.
JEFFRIES, F. B., L.R.C.P.Lond., M.B.C.S., Assistant House Physician to King's College Hospital, London.
PARSONS, A. B. C., L.R.C.P.Lond., M.B.C.S., Junior House Physician to King's College Hospital, London.
ROBERTS, C. HUBERT, M.D.Lond., F.R.C.S., M.B.C.P., Physician to In-Patients at the Samaritan Hospital for Women, London.
WILSON, J. M., M.D.Glasg., D.P.H.Camb., Medical Officer of Health for the Wheatley Urban Sanitary District.

Vacancies.

Bristol Royal Hospital for Sick Children and Women.—House Surgeon. Salary £120 per annum, with rooms and attendance (not board), or £80 with board.
Cornwall County Asylum, Bodmin.—Junior Assistant Medical Officer, unmarried. Salary £100, rising to £120 per annum, with board, furnished apartments, &c.
Devonshire Hospital, Buxton, Derbyshire.—House Surgeon and Assistant House Surgeon for twelve months. Salary of House Surgeon £100 per annum. Assistant House Surgeon £50, with furnished apartments, board, and washing in both cases.
Essex and Colchester Hospital, Colchester.—Resident House Surgeon. Salary £100 per annum, with board and washing.
Holloway Sanatorium Hospital for the Insane, Virginia Water, Surrey.—Junior Assistant Medical Officer. Salary commencing at £100 per annum, with board, lodging, washing, and attendance.
Metropolitan Asylums Board.—A Fourth Assistant Medical Officer at the Asylum, at Darenth, near Dartford, Kent, unmarried. Salary commencing at £150 per annum, with board, lodging, attendance, and washing. Applications to the Clerk of the Asylums Board, Norfolk Street, Strand.
North Riding Asylum, Clifton, York.—Junior Assistant Medical Officer, unmarried. Salary commencing at £125, with board, furnished apartments, washing, and attendance.
Parish of Birmingham Workhouse Infirmary.—Assistant Resident Medical Officer for the Workhouse Infirmary, for one year. Salary £100 per annum, with furnished apartments, rations (no alcoholic liquors), coals, gas, laundry, and attendance. Applications to the Clerk to the Guardians, Parish Offices, Birmingham.
Plymouth Borough Asylum.—Assistant Medical Officer, unmarried. Salary commencing at £125 per annum, with furnished apartments in the Asylum, with board and washing.
Pontefract General Dispensary and Infirmary.—Resident Medical Officer, unmarried. Salary £150 per annum, with furnished rooms, fire, lights, and attendance.
St. Mungo's College, Glasgow, Faculty of Medicine.—Bellahouston Chair of Anatomy. Emoluments £300 per annum.
Stamford Hill and Stoke Newington Dispensary, 189, High Street, Stoke Newington.—Assistant Resident Medical Officer. Salary £100 per annum, with board.
Wolverhampton and Staffordshire General Hospital.—House Surgeon. Salary £100 a year, with board, lodging, and washing. Also Assistant House Surgeon, for six months. Honorarium at the rate of £75 per annum, with board, lodging, and washing.

Births.

BARRETT.—On June 30th, at 65, Rodney Street, Liverpool, the wife of Frank Hugh Barrett, M.D.Lond., F.R.C.S.Eng., of a son.
GONIN.—On June 19th, at Towcester, Northamptonshire, the wife of Edmund Henri Gonin, M.D., of a son.
LAMBE.—On June 20th, at 1, West View, Seaford, wife of Thomas Lambe, M.B.C.S., L.R.C.P., of a daughter.
LISHMAN.—On June 21st, at Puerto Orotava, Tenerife, the wife of Frederick Lishman, M.D., of a daughter.
RUBEL.—On June 19th, at The Red House, River, near Dover, the wife of John L. Rubel, M.B.C.S., L.R.C.P., of a daughter.
SPRIGGE.—On June 19th, at Essex Villas, Kensington, the wife of S. Squire Sprigge, M.B., B.C.Cantab., of a daughter.

Marriages.

BACON—PLATT.—On June 19th, at St. James's Church, West End, near Southampton, Robert A. E. Bacon, L.R.C.P.I., M.B.C.S., only son of Robert Bacon, Esq., R.N., of Sandmere, Southampton, to Elizabeth S. Platt, second daughter of Charles Platt, Esq., B.N. of Wood Leigh, Southampton.
BUT—SHIERS.—On June 21st, at St. Margaret's Church, Dunham Massey, John But, M.B.C.S., L.R.C.P., of Crumpeall, Manchester, to Florence Louisa, youngest daughter of the late Richard Shiers, of Bowdon, Cheshire.
WYLLYS—BALLANCE.—On June 21st, at St. George's Church, Hanover Square, London, Henry John Mackeson Wyllys, F.R.C.S.E., of Great Yarmouth, second son of Dr. Wyllys, of Great Yarmouth, to Bess Louisa, third daughter of the late Charles Ballance, of Clapton.

Deaths.

CHEADLE.—On June 20th, at Chackmore, Buckingham, Thos. A. Cheadle, son of W. B. Cheadle, M.D., of Portman Street, London, W., aged 25.
DAVIES.—On June 16th, at Springfontein, South Africa, Herbert Davies, M.B.Ch.B.Vict., a Surgeon of the Welsh Military Hospital, son of Henry Davies, Carns Lodge, near Lancaster.
EMBLETON.—On June 18th, at Swanage, of apoplexy, Dennis Cawood Embleton, M.D., M.B.C.S., L.R.C.P., of St. Wilfrids, Bourne-mouth, aged 46.
FARR WHITE.—On June 20th, at 3, Leopold Road, Wimbledon, George Farr White, F.R.C.S., late Assist. Surgeon, H.M.'s 77th Regiment.
HOPE.—On June 21st, at Church Hill, Petworth, Samuel Wilson Hope, M.B.C.S., L.R.C.P., in his 56th year.
JONES.—On June 18th, at Springfontein, South Africa, Professor Thomas Jones, F.R.C.S.
JOHNSON.—On June 17th, at Beaconsfield, Bucks, Francis Johnson, M.B.C.S., L.R.C.P.I., aged 50 years.
WHEATLEY.—On June 14th, at The Grange, Loughton, William Henry Wheatley, L.D.S. (Lond. and Glasgow), aged 46 years.

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